

A Strong Start for All Maryland Families

Maryland Workgroup on
Newborn Home Visiting Services

December 2025

Acknowledgements

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Finally, thank you to the Core Team that worked behind the scenes to ensure the Workgroup met the legislative charge with credibility, compassion, and persistence. Special thanks to our colleagues from the Johns Hopkins University, Bloomberg School of Public Health led by Cynthia Minkovitz with Anne Lilly and Alexis Campbell whose expert guidance and data analysis were crucial to creating the landscape analysis and related recommendations. Thanks too to the teams within the Maryland Department of Health who focused on the substance of our work (Iliana Siarmalis, Samantha Ritter, and Meriam Berka of the Maternal and Child Health Bureau and the Office of Family and Child Health) and the process (Jody Sheely, Megan Sehr, and Victoria Marte-Tiburcio of the Office of Support Services, Prevention and Health Promotion Administration), ensuring that the recommendations leverage

commitments in the state to families with young children, and that we carefully followed the Maryland Open Meetings Act to ensure a fair and inclusive process. Finally, thanks to the team at the Maryland Family Network including Laura Weeldreyer who served as Chair of the Workgroup, Beth Morrow, Lisa Klingenmaier, and consultant Deborah Roderick Stark who took responsibility for wrangling the Core Team and the Workgroup members, balancing substantive expertise with a purposeful workplan to meet the legislative requirements.

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Executive Summary

A Strong Start for All Maryland Families

Maryland is committed to ensuring every child and family has the opportunity for a healthy, thriving beginning. We recognize the importance of the earliest days, months, and years of a child's life and know that the first touch -- whether prenatal or shortly after birth -- of a caring, supportive, and experienced home visitor can mean the world of difference for a family. Building strong brain architecture and nurturing connections right from the start creates the foundation for lifelong health and well-being. We also know that a no-wrong-door approach and closed-loop referral linking together a myriad of supports within the perinatal and early childhood system of care can create the conditions for a strong start for all families.

This report of the Maryland Workgroup on Newborn Home Visiting Services builds upon decades of work in the state, including the Pritzker Prenatal-to-Three initiative, the Department of Health's perinatal care continuum, Maternal Health Innovation Program, and the Perinatal and Post-Partum Risk Assessments called for in the Maternal Health Act of 2024. It also builds on lessons learned from existing state and local investments in both care coordination and home visiting. From Baltimore City to Garrett County, and Howard and Frederick County in between, there are examples of evidence-based home visiting nested within a broader system of support offering both short-term universal and long-term targeted home visiting for families. These foundational investments demonstrate true promise for babies and their caregivers. Now, Maryland is ready to consider additional steps to expand what is working so that the state can reach all families with evidence-based programs that are critical for lifelong well-being.

Defining Home Visiting

According to the National Home Visiting Resource Center, "Early childhood home visiting is a service delivery strategy that matches expectant parents and caregivers of young children with a designated support person—typically a trained nurse, social worker, or early childhood specialist—who guides them through the early stages of raising a family. Services are voluntary, may include caregiver coaching or connecting families to needed services, and are provided in the family's home or another location of the family's choice."¹

The Importance of Home Visiting

Home visiting is a proven, evidence-based approach that supports families during the most formative years of a child's life. As a service delivery strategy nested within Maryland's perinatal and early childhood system of care, home visiting bridges gaps in access, fosters strong parent-child relationships, and connects families to a comprehensive array of supports. With 90% of brain development occurring in the

¹ This broad definition of home visiting matches the intention of the Workgroup to reach all families with some level of evidence-based home visiting services. It should be noted, however, that the Maryland Home Visiting Accountability Act of 2012 includes a narrower definition that excludes home visiting programs with few or infrequent visits.

first five years, investing in home visiting yields measurable impacts on child health, safety, school readiness, maternal well-being, and family stability. Equally important, home visiting can have positive impacts on maternal health and well-being.

Purpose and Scope of the Workgroup

The Maryland Workgroup on Newborn Home Visiting Services was established by Governor Moore and the State Legislature in 2025 to explore how best to ensure all families and their babies have a strong start. The Workgroup was charged with analyzing the current landscape, identifying service gaps, and recommending strategies for expanding the reach and impact of home visiting across the state.

Recommendations in Brief

The Workgroup offers the following aspirational recommendations to ensure every Maryland child and family has a strong start, while acknowledging current economic challenges and the need for phased implementation:

- **Infrastructure to Support Universal Home Visiting**
Study the feasibility and benefits of a centralized intake and referral process, supported by a robust data system, to strengthen coordination and access within the perinatal and early childhood system.
- **Alignment to Maximize Efficiency and Minimize Duplication**
Create a home visiting continuum that provides seamless access to the most appropriate models and supports for all families, maximizing efficiency and minimizing duplication across health, education, and social services.
- **Universal + Targeted Home Visiting for Maryland Families**
Implement a voluntary, statewide, universal nurse home visiting program, building upon existing evidence-based efforts. Ensure every family is offered a nurse home visit shortly after birth, with referrals to local services and more intensive supports as needed.
- **Home Visiting Workforce**
Build a culturally responsive home visiting workforce through partnerships, diverse recruitment and training pathways, competitive compensation, and ongoing support to achieve universal + targeted home visiting goals.
- **Financing and Resource Needs**
Secure sustainable, equitable financing for universal + targeted home visiting thorough a permanent health fund, mixed-payer system, and flexible payment models.
- **Public Awareness**
Develop and implement a culturally responsive marketing and outreach campaign to raise awareness and enrollment in voluntary universal + targeted home visiting.
- **Governance and Leadership**
Form and activate a cross-sector leadership coalition to oversee the development and phased implementation of universal + targeted home visiting within the expanded perinatal and early childhood system of care.

Closing

Maryland stands at a pivotal moment. By investing in universal, evidence-based home visiting and reinforcing a comprehensive system of care, the state can deliver on the promise of equity, opportunity, and lifelong well-being for every child and family. As Governor Moore affirms:

“For our children to thrive, they need compassion and support in the early moments of their lives. The science is very clear: zero to three is a critical window. If we don’t get those early years right, everything else becomes details. By giving our kids the best possible head start in life, we’re investing in the collective success of the entire state.”

This report was prepared by the Workgroup on Newborn Home Visiting Services, an independent entity. The findings and conclusions contained herein are solely those of the authors and do not represent the official position of the Maryland Department of Health.

Introduction

A strong start is essential for all Maryland families.

A strong start begins before conception and continues during the prenatal period and through babies' earliest days, months, and years. It is about both the adults and the children and is influenced by both experiences and environments.² It is about access to health care—promoting both physical and emotional well-being—and so much more. A strong start depends on a multitude of factors like safe places to live, worship, and play, access to quality early childhood education programs, and steady income that creates conditions for adults and children alike to flourish. At the heart is the parent-child relationship, a sacred, reciprocal bond that provides buoyancy during times of challenge and security to unleash possibilities for children to reach their unique potential.

Home visiting is an evidence-based strategy that supports families during the earliest years to form strong, safe, and nurturing relationships. Some home visiting models focus primarily on health, others blend health and parenting, and still others emphasize early childhood development and school readiness. Some begin serving families prenatally, others enroll after birth or in the early childhood years. Some offer short-term interventions (1-3 visits), while others offer longer-term care lasting two or more years. All help to connect families to the array of supports that they might need.

"I remember I was standing in line in the grocery store, and I got a call. I was just about 10 weeks pregnant. I don't know how they even knew! I guess it was the health care records. They asked a few questions and explained the home visiting program. I was skeptical because I didn't know who these people were. But I decided to try it out.... Most meaningful has been the support and connection to other parents through our Mommy and Me meetings. Community was so important throughout my pregnancy. They understood what I was going through and that moms need help too. If I'm not feeling supported myself, how can I be a good mother? My nurse is always checking on me and helping me with my goals. Her support throughout my pregnancy and especially these first two years has been so important. I've always struggled with anxiety, and my nurse helps me with that. I can confide in her about the struggles of motherhood and life. She is always there and able to help me navigate these things. When they say it takes a village, I truly believe it does, and for me, starting during my pregnancy was key."

~ Mom from Baltimore City with 18-month-old son

With 90% of brain development occurring in the first five years, investing in families as their child's first and forever teacher is an investment that pays off long into the future. In fact, home visiting has demonstrated impacts on *health, safety, and school readiness of children; maternal health; and family stability and financial security.*³

² Institute of Medicine and National Research Council. (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, DC: The National Academies Press.

³ National Home Visiting Resource Center. (2018). *Home Visiting Primer*. Arlington, VA: James Bell Associates and the Urban Institute.

Studies have found a return on investment (ROI) of \$1.80 to \$5.70 for every dollar spent on home visiting.⁴

Research on Evidence-Based Home Visiting (EBHV)

Since 2009, the US Department of Health and Human Services (HHS) has regularly reviewed the literature on home visiting as part of the Home Visiting Evidence of Effectiveness (HomVEE) Project. HomVEE tracks findings across eight domains: child development and school readiness; child health; family economic self-sufficiency; linkages and referrals; maternal health; positive parenting practices; reductions in child maltreatment; and reductions in juvenile delinquency, family violence and crime. (Please see the Table B-6 in the Appendix for outcomes of EBHV models implemented in Maryland.)

For further information, visit the [HomVEE Project Overview](#).

The Maryland Workgroup on Newborn Home Visiting Services recommends that the State of Maryland commit to building a comprehensive, equitable, and sustainable system of universal and targeted home visiting for all families with newborns. This system should be anchored by a robust infrastructure—including centralized intake and referral, integrated data systems, and coordinated governance—that ensures every family is offered timely, voluntary support during the perinatal period from a qualified home visitor. To maximize impact, Maryland should align and streamline existing programs, expand and support a culturally responsive workforce, secure diverse and sustainable funding sources, and elevate public awareness of home visiting’s benefits. Implementation should be phased and responsive to local needs, with continuous engagement of families and communities, and a focus on reducing disparities and promoting lifelong well-being for every child and family.

Understanding Maryland’s current context is essential for aligning the goal of expanding home visiting with the state’s ability to support it. Entering Fiscal Year (FY) 2026, the state had a \$3 billion budget deficit, necessitating cost reductions and a statewide hiring freeze. Additionally, federal policy shifts, cuts, and the impact of the government shutdown compounded the state’s budget challenges going into FY 2027 and beyond.

Despite this, Maryland remains committed to supporting families with young children by increasing state investments in Pre-K through 12 education and preserving Medicaid while the federal commitment to education and health care wanes. State funding also supports implementation of social support and safety net

⁴ Ibid.

programming, including temporary cash assistance and energy assistance programs, as well as the ENOUGH Act, a state-level effort to address child poverty in select jurisdictions.⁵

For EBHV programs, the FY 26 Maryland budget outlines funding available for programs administered by the Maryland Department of Health (MDH) and the Maryland State Department of Education (MSDE). The FY26 allowance for Maternal, Infant and Early Childhood Home Visiting (MIECHV) grant funds administered through MDH was \$10,521,798⁶, and the approved funding for MSDE's Healthy Families grant was \$4,590,667.⁷

Workgroup on Newborn Home Visiting Services

The Maryland Workgroup on Newborn Home Visiting Services represents a commitment by the Governor and State Legislature to explore how best to ensure all families and their babies have a strong start for a lifetime of well-being. It draws from the wisdom of parents, practitioners, administrators, researchers, and advocates who together chose to lean-in to the concept of thriving children, families, and communities. And it builds upon “bright spots” that already exist in the state and provide a foundation for expansion of perinatal and early childhood systems of care.

Legislative Charge. In May 2025, Governor Moore [signed legislation](#) into law establishing the Workgroup on Newborn Home Visiting Services. The legislation was sponsored in the Senate by Senator Karen Lewis Young (SB 156), and in the House by Delegate Kenneth Kerr (HB 334).

The legislation charged the Workgroup with the following activities:

- (1) Compile updated participant data and expenditures per participant from the home visiting for families with newborns programs currently operating in the State
- (2) Compare the data for home visiting for families with newborns programs in the state to the data for evidence-based models for universal nurse home visiting for families with newborns
- (3) (a) Identify service gaps between the evidence-based models for universal nurse home visiting for families with newborns and operational home visiting for families with newborns programs
(b) Identify opportunities to align the evidence-based models for universal nurse home visiting for families with newborns with operational home visiting for families with newborns programs operating in the State
(c) Identify potential funding sources to close identified service gaps

⁵<https://dbm.maryland.gov/budget/Documents/operbudget/2026/proposed/FY2026MarylandStateBudgetHighlights.pdf>

⁶ <https://dbm.maryland.gov/budget/Documents/operbudget/2026/proposed/FY2026-Volume1.pdf>

⁷ <https://dbm.maryland.gov/budget/Documents/operbudget/2026/proposed/FY2026-Volume2.pdf>

- (4) Identify workforce needs, including issues related to cultural competency, for the evidence-based models for universal newborn nurse home visiting for families with newborns and recommendations to address the workforce needs

Workgroup Composition. The legislation specified the number, appointment authority, and characteristics of Workgroup Members. The following individuals were appointed to serve on the Workgroup:

- Robert Atlas, Chair, OB-GYN Department, Mercy Medical Center
- Erin Bonzon, Administrator, Howard County Office of Children and Families
- Stacey Brown, Executive Director, Family Tree of Maryland
- Emma Cannon, Bilingual Community Health Nurse, Baltimore Medical System
- Alexandra DeRuggiero, Pediatric Population Health Strategy Consultant, Practice Transformation, CAREFIRST
- Rebecca Dineen, Assistant Commissioner, Maternal and Child Health Bureau, City of Baltimore Health Department
- Rachel Dodge, Pediatrician, Dundalk Pediatric Associates
- Maria Friend, Director of Early Care Programs, Garrett County Health Department
- Cathy Gibson, MedStar Southern MD Hospital Center Women and Newborns Center, Milky Moms Lactation Consultant
- State Delegate Jennifer White Holland, District 10
- Natasha Mehu, Vice President, Government Affairs and Policy, Maryland Hospital Association
- Pilar Olivo, Adepta LLC, Executive Project Manager, Family Connects Frederick County
- Mairi Rothman, Midwife, M.A.M.A.S. Midwives⁸
- Iliana Siarmalis, Acting Director, Bureau of Maternal and Child Health, Maryland Department of Health
- State Senator Karen Lewis Young, District 3

At the first Workgroup meeting, Laura Weeldreyer, Executive Director of Maryland Family Network (MFN), was elected Chair, and Pilar Olivo, Executive Project Manager of Family Connects Frederick County, was elected Vice Chair.

Workgroup Process. The Workgroup met virtually four times to address the legislative charge. Material was provided to Workgroup members in advance of each meeting so that they could be prepared for the discussion, and most Workgroup members engaged in homework assignments between meetings as well. All Workgroup meetings were open to the public according to the Open Meetings Act, and the material generated was shared on a [public access website of the Maryland Department of Health](#).

Table 1 provides the date and goals of each Workgroup meeting. Meeting agendas are included in Appendix C.

⁸ Due to a personal matter, Mairi Rothman resigned from the Workgroup on October 27, 2025.

Table 1: Workgroup on Newborn Home Visiting Services Meeting Schedule

Meeting Date	Meeting Goals
September 15, 2025 12-2:30pm	<ul style="list-style-type: none"> ▪ Build relationship / awareness of all Workgroup Members, understanding of the task at hand, and how the Workgroup will conduct its work ▪ Hear from families with newborns to ground our conversation in lived experience ▪ Establish a baseline understanding of the EBHV landscape in Maryland (Legislative Charges 1 and 2) ▪ Elect a Chair and Vice Chair
October 6, 2025 2-4:30pm	<ul style="list-style-type: none"> ▪ Discover the benefits and opportunities for supporting the whole child and whole family through home visiting that is aligned with perinatal and early childhood systems. ▪ Hear insights from home visitors supporting families during the perinatal period and early childhood years. ▪ Understand Maryland’s Bright Spots that can be linked, aligned, and leveraged to create a universal home visiting system of care (Legislative Charges 3 and 4). ▪ Learn from the experience of New Jersey as a state that is implementing universal newborn home visiting, including alignment with other models and systems, staffing and financing (Legislative Charges 3 and 4).
October 31, 2025 12-2:30pm	<ul style="list-style-type: none"> ▪ Increase understanding of pregnant and parenting families across the state as we hear from Workgroup members who conducted focus groups. ▪ Discuss and vote on proposals related to home visiting reach, alignment, and infrastructure. (Legislative Charges 1, 2, and 3) ▪ Engage in learning, discussion, and ideation related to the home visiting workforce and financing. (Legislative Charges 3 and 4)
November 20, 2025 9-11:30am	<ul style="list-style-type: none"> ▪ Discuss and vote on proposals related to home visiting workforce, finance, public awareness, and governance/leadership (Legislative Charges 3 and 4) ▪ Discuss and vote on the final Workgroup report

Public Input: The Workgroup implemented multiple approaches for gathering public input. An essential tenet was to engage those with lived expertise. This is informed by current best practice for developing equitable programs, policy, and research.

Engagement took several forms:

- **Parent Panel:** Three parents shared their home visiting experiences as part of a panel at the September 15, 2025 Workgroup meeting. The parents included: Cin'Cere Barnes of Baltimore City (Nurse Family Partnership); Sarah Boyd of Brooklyn (HIPPI); and Alyssa Franklin of Frederick (Family Connects).
- **Home Visitor Panel:** Three home visitors shared their experience working with families at the October 6, 2025 Workgroup meeting. The home visitors included: Whedly Beutelus of Prince Georges County (Healthy Families America); Emma Cannon of Baltimore Medical System and Baltimore City Health Department (Nurse Family Partnership); and Lori Sprecher of Frederick County (Family Connects).
- **Parent Focus Groups:** Several Workgroup members facilitated focus groups to gather even more input from families raising young children. These included:
 - **Baltimore City:** Workgroup member Emma Cannon conducted a focus group on October 3, 2025 with families who participated in a range of community-based services through Baltimore Medical System, including Nurse Family Partnership, perinatal Centering programs, Mom's Club, and more.
 - **Frederick County:** Workgroup member Pilar Olivo secured support from Frederick Health Hospital to engage Market Street Research to facilitate two focus groups on October 14, 2025 with families who recently completed participation in Family Connects.
 - **Garrett County:** Workgroup member Maria Friend conducted a focus group on October 16, 2025 with families enrolled in multiple programs (Nurse Family Partnership, Healthy Families).
 - **Howard County:** Workgroup member Erin Bonzon conducted a focus group on October 24, 2025 with families served by two home visiting models (Parents as Teachers, Healthy Families).
- **Public Hearing:** A public hearing was held on October 7, 2025. Forty-Seven people attended the hearing, including members of the public (30), members of the Workgroup (7), and staff for the Workgroup (10).
- **Website:** MDH created a landing page for the Workgroup that included the membership, charge, and information for each meeting (e.g., agenda, recording, background material, and approved minutes). The website also included an email for anyone to submit questions or comments which were then shared with the Workgroup.

Workgroup Decision-making. To the extent possible in a virtual setting, members of the Workgroup engaged in "Proposal Based Decision-making." Proposal Based Decision-making is a practice advanced by the Annie E. Casey Foundation to support groups in taking the temperature of the room by inviting proposals and then fine tuning around the edges to move as close to full member agreement as possible. The gathering of ideas on proposals via homework assignments and the ability to indicate one's leanings on consolidated proposals was meant to offer a modified version of Proposal Based Decision-making by crowdsourcing ideas among the Workgroup and looking for alignment.

The Workgroup transitioned to traditional voting according to Roberts' Rules of Order for each recommendation and the final report. While the desire was to advance a consensus report, all members were invited to provide a written dissent to be included in the Appendix of this report.

Workgroup Staffing. The legislation stated that the MFN and the MDH “may” provide staff support for the Workgroup. Multiple staff from both entities were engaged throughout the process. In addition, faculty and staff from the Johns Hopkins University Bloomberg School of Public Health played an essential role in gathering, analyzing, and reporting the data for the landscape analysis. That data is included in this report.

Together, the staff team consisted of:

- **MARYLAND FAMILY NETWORK**
 - Laura Weeldreyer, Executive Director
 - Beth Morrow, Director of Public Policy
 - Lisa Klingenmaier, Deputy Director of Public Policy
 - Deborah Roderick Stark, Consultant
- **MARYLAND DEPARTMENT OF HEALTH**
 - Iliana Siarmalis, Acting Director, Maternal and Child Health Bureau
 - Jody Sheely, Director, Office of Support Services, Prevention and Health Promotion Administration
 - Samantha Ritter, Director, Office of Family and Child Health Services
 - Megan Sehr, Health Policy Analyst I, Office of Support Services, Prevention and Health Promotion Administration
 - Victoria Marte-Tiburcio, Health Policy Analyst, Office of Support Services, Prevention and Health Promotion Administration
 - Meriam Berka, Epidemiologist, I, MIECHV, Office of Family and Child Health Services
- **JOHNS HOPKINS UNIVERSITY BLOOMBERG SCHOOL OF PUBLIC HEALTH**
 - Cynthia Minkovitz, Sr. Professor and Department Chair
 - Anne Lilly, Sr. Research Associate
 - Alexis Campbell, Sr. Research Program Coordinator II

The Well-Being of Children and Families in Maryland

Each year, approximately 66,000 babies are born in Maryland -- each one deserving an equal chance at a healthy, thriving, strong start. Yet beneath this hopeful number lies a troubling reality: deep and persistent disparities in access to care, support, and resources are putting some families -- especially those in historically marginalized communities -- at a disadvantage. Not only does this influence child well-being, it also influences the conditions underlying maternal health as well. These inequities are not just statistics; they are lived realities for parents navigating complex systems, and for infants whose futures are shaped by the zip code they are born into.

Maryland is actively advancing a coordinated perinatal and early childhood system of care that supports the health and well-being of birthing people, infants, and families before, during, and after birth. Local jurisdictions are implementing innovative models and partnerships, efforts which are strengthened by a statewide strategy designed to align priorities, braid funding, and provide shared infrastructure and standards. State leadership and sustained investment are essential to ensure that local programs can grow equitably, that services are cohesive rather than fragmented, and that families across Maryland benefit from a strong, connected system of support.

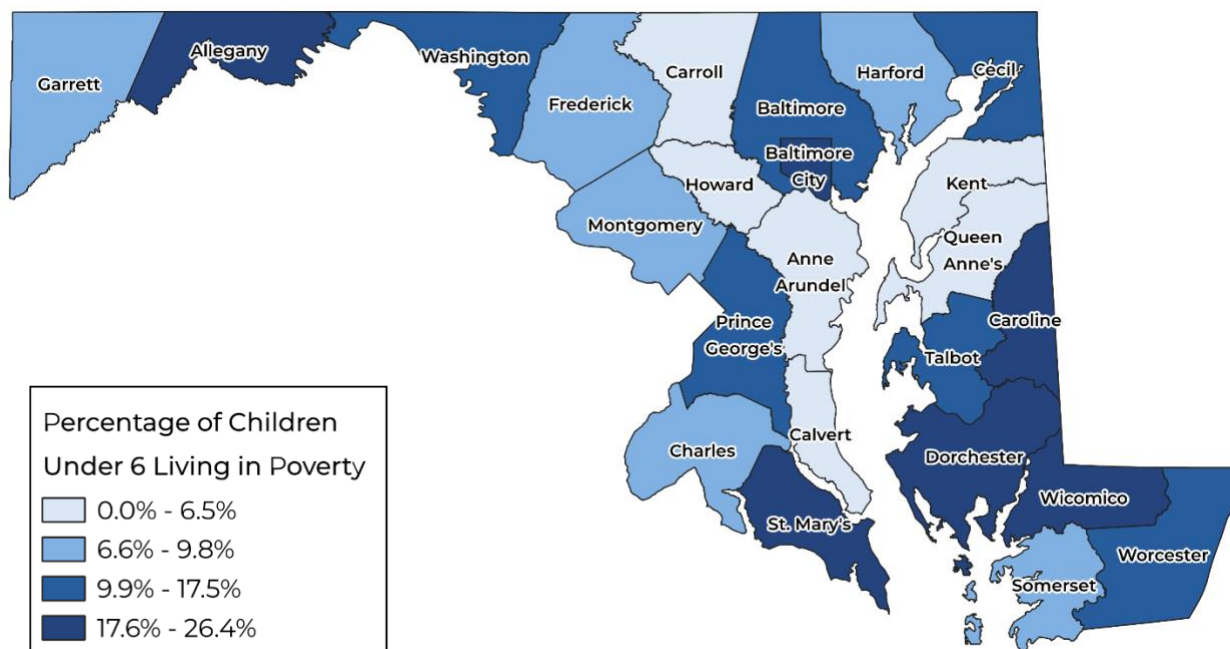
Characteristics of Families with Children Under Age Six. Maryland's young children are racially, ethnically, and culturally diverse: 40.6% are White, 29.0% are Black or African American, 14.5% are two or more races, 10.4% are some other race, 5.1% are Asian, <1% are American Indian or Alaska Native, <1% are Native Hawaiian or Other Pacific Islander, and 20.5% are Hispanic or Latino.⁹ The distribution of race and ethnicity varies across jurisdictions (Appendix Table B-1).

Of the 424,833 children under age six, 12.2% live in poverty.¹⁰ While the percentage of Maryland children in poverty is lower than the national percentage (17.5%); the percentage of children living in poverty in six Maryland jurisdictions exceeds the national average (Appendix Table B-2). Figure 1 highlights this variability across jurisdictions. Further, the percentage of children under age six living in poverty varies notably by race and ethnicity; the percentages are highest among children who are American Indian or Alaskan Native (20.4%), followed by Black or African American (19.0%) and some other race (19.0%).⁵

⁹ Sex by Age. US Census Bureau, B01001 series, 2019-2023 American Community Survey 5-Year Estimates.

¹⁰ Poverty Status in the Past 12 Months by Age. US Census Bureau, B17020, 2019-2023 American Community Survey 5-Year Estimates.

Figure 1. Percentage of Children Under 6 Living in Poverty by Jurisdiction, 2023



Estimates of children under six living in poverty do not fully estimate households constrained by limited income. In 2023, an estimated 39% of all households in Maryland could not afford basic needs such as housing, child care, food, transportation, health care, and technology.¹¹ Some of these households have incomes below the Federal Poverty Level (FPL). Households with incomes exceeding the FPL that still experience financial hardship are Asset Limited, Income Constrained, Employed (ALICE). In Maryland, 29% of households met ALICE criteria and had incomes above the FPL. The percentage of ALICE households ranged from 22% in St. Mary's County to 37% in Caroline and Somerset Counties.⁶

Access to safe, affordable housing is critical for a variety of health and well-being indicators, including physical and mental health for all family members, and educational outcomes for children.⁶ In 2022, 50.3% of Maryland renters were cost burdened, meaning they spent more than 30% of their income on housing costs. Housing affordability in Maryland also varies by race and geography. Black households experience a disproportionate lack of access to affordable housing, with 49.3% of Black renters being cost burdened compared to 40.7% of White renters. Garrett County had the lowest percentage (34.7%) and Somerset County had the highest percentage of renters cost burdened (59.9%).¹²

¹¹ <https://www.unitedforalice.org/maryland>

¹² <https://dhcd.maryland.gov/Documents/Research/Compiled-Report-SHNA-2025.pdf>

Among Maryland children under six years of age, about a third (32.7%) have one or more foreign-born parent, which exceeds the national average (24.1%).¹³ These percentages vary considerably by jurisdiction. High percentages have implications for workforce development, family engagement, and culturally appropriate service delivery.

Birthing Population and Maternal and Child Well-Being Outcomes. Although several infant and maternal health indicators in Maryland are more favorable than those for the US, disparities by race, ethnicity, and geography persist for low birth weight, preterm birth, and infant mortality.

For many infant and maternal health indicators, Maryland's outcomes mirror those at the national level. Maryland's low birth weight rate matches that of the US (8.6%) and the preterm birth rate is nearly the same (Maryland 10.2%, US 10.4%).^{14,15} From 2018–2022, Maryland's maternal mortality rate, 21.3 per 100,000 live births, was more favorable than that of the US (23.2 per 100,000).¹⁶ Two Maryland birth outcomes are slightly less favorable when compared to the US. Maryland experiences higher rates of inadequate prenatal care (7.4%, US 7.0%) and infant mortality (5.7 deaths per 1,000 live births, US 5.6 deaths per 1,000 live births).^{8,9,17}

Racial and ethnic disparities for birth outcomes in Maryland echo the trend observed at the national level, with non-Hispanic Black infants having the highest rates of low birth weight, preterm birth, and infant mortality (Table 2). The infant mortality rate for non-Hispanic Black infants is more than twice that of non-Hispanic White infants and the inadequate prenatal care rate for Hispanic (13.5%) and non-Hispanic Black (8.5%) women is substantially higher than that for non-Hispanic White (3.6%) women.

¹³ Age and Nativity of Own Children Under 18 Years in Families and Subfamilies by Nativity of Parents. US Census Bureau, C05009, 2023 American Community Survey 1-year estimates.

¹⁴ Maryland Vital Statistics Annual Report 2023.

¹⁵ Osterman MJK, et al. [Births: Final data for 2023](#). National Vital Statistics Reports; vol 74, no 1. Hyattsville, MD: NCHS. 2025.

¹⁶ [Maternal deaths and mortality rates](#): Each state, DC, and US, 2018 – 2022. NCHS, NVSS.

¹⁷ Ely DM, et al. [Infant mortality in the US: Provisional data from the 2023](#) period linked birth/infant death file. Vital Statistics Rapid Release; no 37. Hyattsville, MD: NCHS. 2024.

Table 2. Selected Birth and Death Outcomes in Maryland by Race and Ethnicity, 2023

Race/ethnicity	Total Births	Inadequate Prenatal Care (% of births with late or no prenatal care)	Low Birth Weight (% live born infants <2,500 g)	Preterm Birth (% infants born <37 weeks)	Infant Mortality Rate (Deaths per 1,000 live births)
Non-Hispanic American Indian	71	**	**	**	**
Non-Hispanic Asian or Pacific Islander	4,328	4.9	8.5	8.8	**
Non-Hispanic Black	18,791	8.5	12.9	13.0	9.0
Non-Hispanic Multi-race	1,935	7.2	9.0	10.2	**
Non-Hispanic White	25,603	3.6	6.3	8.6	3.7
Hispanic	14,425	13.5	7.1	10.0	4.8
All Races	65,578	7.4	8.6	10.2	5.7

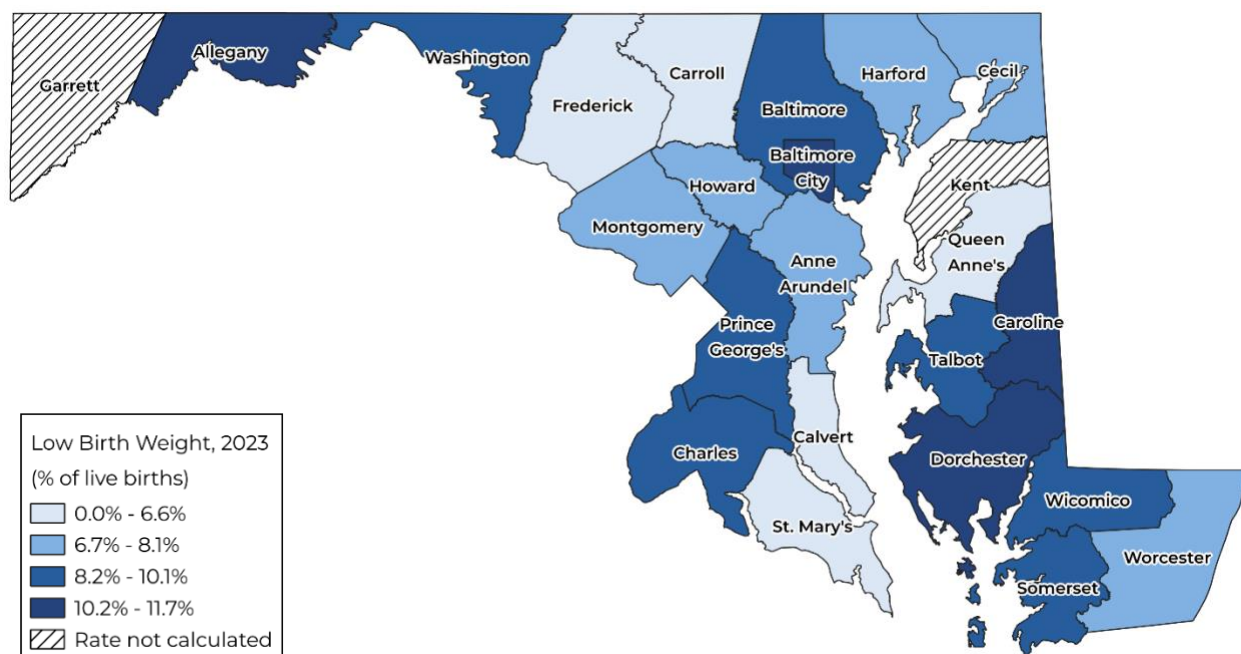
Source. Maryland Vital Statistics Annual Report 2023. Persons of Hispanic origin may be of any race. The “all races” category includes races categorized as “unknown” or “other.”

** Percentages or rates based on <220 events are not presented since such percentages or rates are subject to instability.

Variability also persists in low birth weight, preterm birth, and infant mortality data by jurisdiction (Appendix Table B-3). Low birth weight rates range from a low of 5.7% in St. Mary’s County to a high of 11.7% in Baltimore City. Percentages of infants born preterm range from 8.0% in Garrett County to 13.0% in Dorchester County and the infant mortality rate varies from 3.7 deaths per 1,000 live births in Frederick to 10.9 deaths per 1,000 deaths in Allegany County.

Figure 2 illustrates the variability of infants born low birth weight in 2023 by jurisdiction. Allegany, Caroline and Dorchester Counties and Baltimore City have the highest percentages of infants born low birth weight; while Calvert, Carroll, Frederick, Queen Anne’s and St. Mary’s Counties have the lowest percentages of low-birth-weight births.

Figure 2. Percent of Infants Born Low Birth Weight by Jurisdiction, 2023¹⁸



In 2023, approximately 15 per 1,000 Maryland children were subject to a child maltreatment investigation compared to 42 per 1,000 US children. Of all children investigated for child maltreatment, about 5 per 1,000 Maryland children and 7 per 1,000 US children experienced child maltreatment. Across age groups, in both Maryland and at the national level, child maltreatment is most prevalent among children under one year of age (6.4 per 1,000 Maryland; 21.0 per 1,000 US).¹⁹ Maryland's rates of child maltreatment are consistently lower compared to US rates.

The Maryland Maternal Mortality Review 2022 Annual Report indicates that there were 58 pregnancy-associated deaths in 2020, an increase of 27 deaths compared to the previous year. The leading cause of all pregnancy-associated deaths, including pregnancy-related and non-pregnancy related deaths, was behavioral health conditions, including substance use disorder and depression. This is different from 2019, for which the leading causes of pregnancy-related deaths were hemorrhage, non-cardiovascular conditions, and pregnancy-induced hypertension. The Maternal Mortality Review Committee (MMR Committee) reports that the majority of these deaths were considered preventable and recommends care coordination, social determinants screening across multiple providers, pregnancy planning resources, and standard investigation procedures concerning pregnancy-associated deaths.²⁰

¹⁸ Maryland Vital Statistics Annual Report 2023.

¹⁹ U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2025). Child Maltreatment 2023. Available from <https://www.acf.hhs.gov/cb/data-research/child-maltreatment>.

²⁰ <https://health.maryland.gov/phpa/mch/Documents/MMR/2022%20MMR%20Report.pdf>

Further, the report states that from 2016-2020, the non-Hispanic Black maternal mortality rate was 2.3 times higher than non-Hispanic White maternal mortality rate.

Severe maternal morbidity (SMM), including potentially life-threatening conditions, is on the rise in Maryland, occurring among birthing parents across insurance types (54% of those with SMM had Medicaid and 41% had private insurance). More than two-thirds of SMM events occurred postpartum, most within 8-72 hours of delivering. Further, the rate was more than double for non-Hispanic Black patients than non-Hispanic White patients (157.0 SMM events per 10,000 deliveries compared to 71.4 SMM events per 10,000 deliveries, respectively).²¹

Across the nation, there is growing recognition of the importance of perinatal mental health in contributing to maternal and child outcomes.²² One in five women experience mental health or substance use disorder during the perinatal period (pregnancy through 1-year post-partum), a time in the life course that that is mixed with additional stressors as well as excitement of welcoming a new family member.²³ It is also a time when many parents are receptive to new services and when attention to the importance of parental self-care can help to optimize health and well-being outcomes. A lack of systems across the US to address mental health during the perinatal period hinder the ability of providers and communities to deliver the support needed. The Policy Center for Maternal Mental Health gives Maryland a “C” on the 2025 state report card,²⁴ slightly better than the “C-” in 2023. Ideally, there would be universal detection and screening for all pregnant and post-partum parents, a seamless system of care that includes access to mental health services, and data systems to track outcomes at a population level.

Scope of Perinatal Health Services in Maryland. Maryland’s perinatal system of care serves families from pregnancy up to child age three and includes an array of supports, including health insurance, family support programs, early care and education programs, and care coordination programs.

Health insurance. Health insurance is a key factor in ensuring access to clinical care, including prenatal and infant health care. Among the approximate 66,000 live births in Maryland in 2023, 51.6% of births were covered by private insurance, 41.6% by Medicaid, 3.7% other payment, and 2.9% self-payment.²⁵

According to the 2022-2023 National Survey of Children’s Health (NSCH), 95% of Maryland children birth through age five have health insurance coverage and 5% are

²¹ https://mdmom.org/sites/default/files/documents/2025_MDMOM_SMM_Report.pdf

²² <https://www.psychiatry.org/getmedia/344c26e2-cdf5-47df-a5d7-a2d444fc1923/APA-CDC-Perinatal-Mental-and-Substance-Use-Disorders-Whitepaper.pdf>

²³ Ibid.

²⁴ The Policy Center for Maternal Mental Health. (2025, May). Maternal Mental Health State Report Card (2025). <https://www.policycentermmh.org/state-report-cards>

²⁵ Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Accessed on Jul 29, 2025. <http://wonder.cdc.gov/natality-expanded-current.html>

uninsured. Among those who are insured, 63.8% have private health insurance, 27.4% have public health insurance, and 3.8% have a mix of public and private health insurance.²⁶ While the NSCH estimate for uninsured Maryland children under age five is lower than the national average of 6.2%, considerable variation exists across jurisdictions. 2023 Census data estimate that the percentage of children under age six uninsured in Maryland ranges from 0.9% in Calvert County to 22.1% in Kent County.²⁷

Family supports. Maryland offers a variety of family support programs that foster maternal and child health. While we cannot include all of Maryland's family support programs in this report, six examples of family support programs include: Judy Center Early Learning Hubs, Patty Centers, the Maternal Opioid Misuse Program (MOM), the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

- Judy Center Early Learning Hubs connect caregivers and families living in their catchment areas to developmental screenings, parenting classes, adult education opportunities, home visiting programs, and child playgroups. Services are available for pregnant people and families with children up to age six. As of 2024, there were 86 Judy Centers across Maryland, with at least one Judy Center in each of Maryland's 24 jurisdictions.
- Patty Centers, formerly known as Family Support Centers, support families with children birth to three years of age by promoting healthy child development and helping families access support services they want and need. Patty Centers in 13 jurisdictions offer programming on positive parenting techniques, nutrition, and adult education.
- The MOM program supports pregnant and postpartum Medicaid participants diagnosed with opioid use disorder prenatally through the first birthday of their child. The MOM program provides participants with case management services and linkages to prenatal and postpartum clinical care and behavioral health treatment.²⁸
- SNAP helps families purchase food to support the nutritional needs of their households.
- The Temporary Cash Assistance (TCA) program, Maryland's TANF program, provides cash assistance and supportive services to families with dependent children to strengthen the family's economic stability.
- WIC provides nutrition education, breastfeeding promotion and support, supplemental foods, and service referrals for eligible pregnant, breastfeeding, and postpartum people; and infants and children up to the age of five.

Early care and education. Early childhood care and education programs support learning experiences for infants and young children to age three. Young children in

²⁶ 2022-2023 National Survey of Children's Health, Indicator 3.3: Type of health insurance.

²⁷ Selected Characteristics of Health Insurance Coverage in the United States. US Census Bureau, S2701, 2019-2023 American Community Survey 5-Year Estimates.

²⁸ <https://health.maryland.gov/mmcp/pages/mom-model.aspx>

Maryland receive early childhood care and education in a variety of settings, including child care centers, family child care homes, and Early Head Start programs. Child care centers and family child care homes are available across Maryland's 24 jurisdictions, and center-based Early Head Start Programs operate in 15 jurisdictions.²⁹

Maryland prioritizes quality early care and learning opportunities, however, a family's ability to access quality child care depends, in part, on their ability to cover out-of-pocket costs. Due to developmental needs, infants and toddlers require more individualized care than older children, resulting in higher costs of care. Additionally, as program quality increases, so do expenses. The Child Care Scholarship (CCS) Program is an income eligibility-based program that helps families with low incomes offset the high costs of child care. Child care centers and family child care homes in Maryland can receive reimbursement from the CCS program if they participate in Maryland EXCELS—Maryland's voluntary quality rating improvement system.

Care coordination. Many care coordination models across Maryland work to connect families with quality care and services. Below, we highlight three perinatal care coordination programs that link pregnant and postpartum people and their children with services they want and need.

- Health Care Access Maryland (HCAM) helps families enroll in affordable health coverage and connects families with services they want and need. HCAM is a key component of Baltimore City's B'more for Healthy Babies initiative and leverages Baltimore's City's centralized intake system to implement its Care Coordination Program (CCP). The HCAM CCP connects pregnant people with Medicaid to critical services that support a healthy pregnancy, including obstetric care, health services, and community resources. Through the centralized intake system, CCP also makes referrals to WIC, early intervention services, and EBHV.³⁰
- MDH's Babies Born Healthy Initiative aims to reduce disparities in infant mortality, with a focus on non-Hispanic Black populations. The initiative supports perinatal care coordination to connect birthing people and infants to psychosocial support services, prenatal health care, health and nutrition education, and community-based services. Babies Born Healthy also funds a doula training hub and implementation of the CenteringPregnancy model of group-based prenatal care. Babies Born Healthy currently operates through the local health departments in Anne Arundel, Baltimore, Caroline, Charles, Montgomery, Prince George's and Wicomico Counties and Baltimore City.
- The Thrive by Three grant program, established in 2018, provides grants to counties and municipalities to support care coordination services for pregnant and postpartum people and children from birth to age three with low incomes. Thrive by Three connects families to home visiting programs, maternal depression screening, early intervention services, health insurance,

²⁹ <https://www.marylandfamilynetwork.org/for-advocates/maryland-child-care-mapping>

³⁰ B'more for Healthy Babies: The story behind the data. The Abell Foundation. 2023.

and nutrition programs. At the beginning of FY 2026, Thrive by Three supported local health departments in Baltimore City, Frederick County, Harford County, Somerset County, St. Mary's County, and Wicomico County; and two Federally Qualified Health Centers: Greater Baden Medical Services and Mary's Center.

Across these three care coordination models, eleven jurisdictions have one or more care coordination program (Appendix Table B-4).

Additional Public Health Infrastructure and Initiatives. The Title V Maternal and Child Health Services Block Grant supports Maryland's perinatal system of care by providing funds that ensure access to quality health care services for caregivers and young children. The Maryland Maternal Health Innovation Program aims to improve maternal health across the state. And the Integrated Maternal Health Strategy aims to increase rates at which high-risk pregnant and post-partum people are identified by their care team and connected to services.

Title V. MDH's Prevention and Health Promotion Administration's Maternal and Child Health Bureau administers Maryland's Title V Maternal and Child Health Services Block Grant. Title V supports the availability, accessibility, and quality of primary and specialty care services for women, infants, and children, including children with specific health care needs. Specifically, Title V funds an array of services throughout the perinatal health system, including reproductive health clinics, the Babies Born Healthy care coordination program, and home visiting.³¹

MDMOM initiative. The Maryland Maternal Health Innovation Program (MDMOM) is a coordinated effort between Johns Hopkins University, MDH, and the Maryland Patient Safety Center to improve maternal health across Maryland. MDMOM encompasses multiple initiatives to address maternal health, including birthing hospital training, maternal morbidity surveillance, warning signs education, and prevention of perinatal depression. Thirty-two birthing hospitals across 18 jurisdictions participate in MDMOM with each hospital having participated in at least one of MDMOM's hospital training initiatives.³² MDMOM also created the publicly available Maryland Maternal Health Resource Map, which displays resources available to pregnant and postpartum people and their families. The [map](#) provides 26 different types of resources available across Maryland's 24 Jurisdictions.

Integrated Maternal Health Strategy. Funded by the US HHS Health Resources and Services Administration, MDH administers Integrated Maternal Health Strategy (IMHS) program, which aims to increase rates at which high-risk pregnant and postpartum people are identified by their care team and connected to needed services in their communities by digitizing key risk assessment forms and enhancing care coordination services. The program also seeks to improve the capacity of the

³¹ Maryland Maternal and Child Health Services Title V Block Grant. FY 2025 Application/FY 2023 Annual Report.

³² <https://mdmom.org/hospital-initiative>

perinatal workforce to provide trauma-informed, culturally responsive care and increase those with perinatal mental health training.

The Home Visiting Landscape in Maryland

The 2024 National Home Visiting Yearbook estimates that 321,600 families in Maryland with children under age six could benefit from EBHV programs.³³ These are families who meet one or more priority criteria (i.e., child under age one, single mother, parent with no high school diploma, pregnant woman or mother under age 21, low income).³⁴ Yet only 4,319 families received home visiting services. This illustrates a significant gap in reaching the families who might benefit the most.

Home Visiting Model Implementation. Maryland offers an array of home visiting services including EBHV programs, evidence-informed programs, and other types of home visiting.

Evidence-Based Home Visiting.

The HHS HomVEE initiative established criteria to identify evidence-based models and conducts regular reviews of the evidence to update which models are included. The HomVEE review focuses on eight outcome domains: (1) child development and school readiness, (2) child health, (3) family economic self-sufficiency, (4) linkages and referrals, (5) maternal health, (6) positive parenting practices, (7) reductions in child maltreatment, and (8) reductions in juvenile delinquency, family violence, and crime. To achieve evidence-based designations, home visiting model research must be well-designed, replicable, and peer-reviewed and demonstrate favorable outcomes in at least two of the eight outcome domains. Furthermore, the demonstrated model impacts on participant outcomes must be sustained for at least 12 months after participant enrollment.³⁵ Across all models implemented in Maryland and with evidence-based

"I've never loved anyone as much as I love my daughter Aurora. I had an emergency c-section. The day before I was discharged, a nurse came to my room and offered a home visit. I love free medical care, and I will never say no! ... The program truly saved my life. Like many Black women, I had post-natal preeclampsia. I didn't know any of that until the nurse came to my home. She checked my blood pressure and said I needed to go to the hospital. I was worried about what I would do with the baby, but the nurse made sure that the baby could be with me. Even after that was addressed, I had another nurse visit as home to check on me and Rory. I was tested and given formula. As a new mother, the home visiting program was integral to my mental and physical health, and to my baby as well."

~ Mom from Frederick County with a one-year-old daughter.

³³ https://nhvrc.org/state_profile/maryland-2024/

³⁴ Priority criteria include: child under age one, single mother, parent with no high school diploma, pregnant woman or mother under age 21, low income.

³⁵ <https://homvee.acf.gov/about-us/hhs-criteria>

designations, Healthy Families America and Nurse-Family Partnership report favorable outcomes across all 8 domains, while others report favorable outcomes across 2 or more domains (Appendix Table B-5).

Prior to 2025, seven EBHV models were implemented in Maryland: Attachment Bio-Behavioral Catch-Up (ABC), Early Head Start's home-based option (EHS), Family Connects (FC), Healthy Families America (HFA), Home Instruction Program for Preschool Youngsters (HIPPOY), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT). By 2026, Maryland MIECHV will support two new EBHV programs: the Maternal Infant Health Outreach Worker Program (MIHOW) in Montgomery County, and the Maternal Early Childhood Sustained Home-visiting Program (MESCH) in Worcester County.

Table 3 presents information on service enrollment, service dose, service duration, and providers for seven EBHV models. Six models (ABC, EHS, FC, HFA, NFP, PAT) can serve newborns; HIPPOY is the exception, as the model starts enrollment after the child's second birthday. NFP is the only model that requires prenatal enrollment. EHS, HFA, and PAT allow prenatal and postnatal enrollment with HFA preferring prenatal enrollment when possible. FC requires bedside recruitment of families prior to hospital discharge. For EHS, HFA, HIPPOY, NFP, and PAT, service dose is frequent and service duration can be categorized as long-term. These models typically work with caregivers and their children on a weekly or monthly basis for multiple years. ABC and FC offer a lower dose and shorter duration of home visiting services. Home visitors implementing the ABC model meet with caregivers and their children for ten weeks. Home visitors implementing the FC model must be registered nurses, engage with families up to 12 weeks postpartum, and meet with caregivers and their newborn once within three weeks postpartum, with up to two additional visits dependent on family needs. In addition to differences in service enrollment, dose and duration, models also vary in their eligibility requirements (Appendix Table B-6).

A program's dose and duration impact the capacity to serve families, with short-term models usually having a larger reach. However, having a mix of long- and short-term models enables families to choose a program that fits their wants and needs. In 2023, the seven evidence-based models operating in Maryland served approximately 4,319 families. Of these, 1,754 families were served by long-term EBHV, and 2,565 families were served by short-term EBHV (Table 4).

Table 3. Comparison of EBHV Models in Maryland*

Model	Service Enrollment	Service Dose	Service Duration	Providers**
ABC	<ul style="list-style-type: none"> • Postnatal only • Child 0-23 mos 	<ul style="list-style-type: none"> • Weekly visits 	<ul style="list-style-type: none"> • 10 weeks 	<ul style="list-style-type: none"> • Paraprofessionals
EHS	<ul style="list-style-type: none"> • Prenatal or postnatal • Child <36 mos 	<ul style="list-style-type: none"> • Weekly visits • 24 group visits/year 	<ul style="list-style-type: none"> • Up to 35 months 	<ul style="list-style-type: none"> • Paraprofessionals
FC	<ul style="list-style-type: none"> • Postnatal only • Child 0-6 mos 	<ul style="list-style-type: none"> • One visit • Up to 2 additional visits if needed 	<ul style="list-style-type: none"> • Up to 12 weeks 	<ul style="list-style-type: none"> • Registered nurses
HFA	<ul style="list-style-type: none"> • Prenatal or postnatal • Child <3mos 	<ul style="list-style-type: none"> • Weekly visits 	<ul style="list-style-type: none"> • Pregnancy thru 3rd birthday • Can extend to 5th birthday 	<ul style="list-style-type: none"> • Paraprofessionals
HIPPY	<ul style="list-style-type: none"> • Postnatal only • Child 2-5 yrs 	<ul style="list-style-type: none"> • Weekly visits • 6 group visits/year 	<ul style="list-style-type: none"> • Three years or more 	<ul style="list-style-type: none"> • Paraprofessionals
NFP	<ul style="list-style-type: none"> • Prenatal only • <28 wks gestation 	<ul style="list-style-type: none"> • Prenatal to 21 mos: weekly or every other week • 21-24 mos: monthly visits 	<ul style="list-style-type: none"> • Pregnancy thru 2nd birthday 	<ul style="list-style-type: none"> • Registered nurses or paraprofessionals
PAT	<ul style="list-style-type: none"> • Prenatal or postnatal • Child <5yrs 	<ul style="list-style-type: none"> • 1 visit/month (more frequent if needed) • 12 group visits/year 	<ul style="list-style-type: none"> • Pregnancy thru kindergarten entry 	<ul style="list-style-type: none"> • Paraprofessionals

Source: HomVEE model descriptions. <https://homvee.acf.gov/> **Providers column highlights minimum staffing requirements. *Models active in Maryland prior to 2025

Table 4. Maryland Families Served by Evidence-Based Home Visiting (EBHV), by Model, 2023

Model	Number of Families Served
Long-term EBHV	
EHS home-based	27
HFA	1,377
HIPPY	51
NFP	231
PAT	68
Short-term EBHV	
ABC	5
FC	2,560
TOTAL	4,319

Source: Joraanstad, A. & Meisch, A.D. (2024). Maryland home visiting service data by evidence-based model, Fiscal Year 2023. National Home Visiting Resource Center.

As of fall 2025, all Maryland jurisdictions have at least one EBHV program. Figure 2 presents the reach of six EBHV models across jurisdictions, while Table 5 presents the number of these EBHV programs by model across Maryland’s 24 jurisdictions. Both figures exclude ABC as the model was not implemented in Maryland in 2025.

Figure 2. Evidence-Based Home Visiting Models by Jurisdiction, September 2025

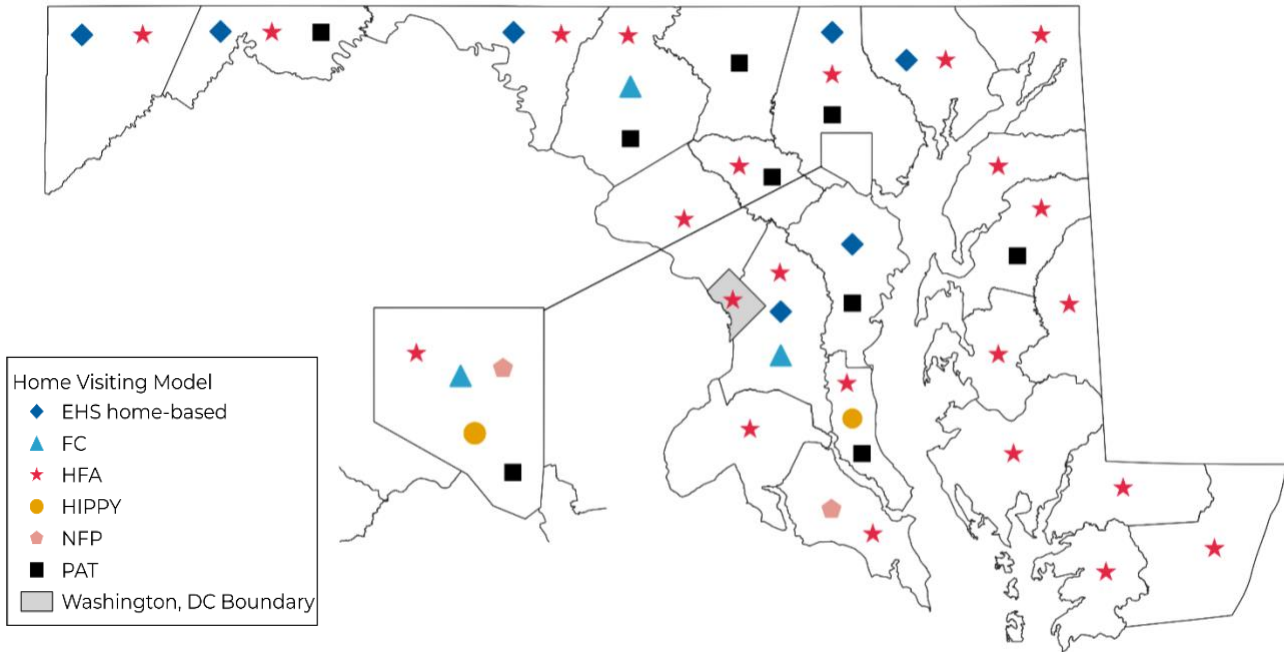


Table 5. Evidence-Based Home Visiting Model Reach in Maryland

Model	Number of Programs	Number of Jurisdictions
Early Head Start Home-based (EHS)	6	7
Family Connects (FC)	3	3
Healthy Families America (HFA)	25	22
Home Instruction for Parents of Preschool Youngsters (HIPPY)	2	2
Nurse-Family Partnership (NFP)	2	2
Parents as Teachers (PAT)	10	9
Total	48	24

Sources. Correspondence with Maryland Department of Health and Maryland State Department of Education and review of national model websites.

"I imagined they would come to check on the baby, but I did not imagine they were going to give me so much help." ~ Frederick County Parent

"We discounted in ourselves our own ability to be nurturers. Our Parent Educator reassured and modeled for us that our new parenting hang ups are normal. We as parents are normal." ~ Howard County Parent

"Emotional support that won't judge me." "Help me with resources." ~ Garrett County Parent

"[Home Visitors] meet you where you are. They are willing to stand with you and go along with you on this parenthood ride." ~ Howard County Parent

"I had a lot of feelings when she came over I didn't feel alone anymore...when I most needed them, they were there...I will never forget these visits that they made...I did not feel like going out, I didn't feel like speaking, and they motivated me...she told me that I could do more than I thought I could, she was there to motivate me." ~ Baltimore City Parent

"The most helpful things was the resources she gave that I needed. Things I didn't know about, like helping me with the breastfeeding and his latch and learning about pumping, because I really needed help. Otherwise, I wouldn't have been able to give my baby my breast milk." ~ Frederick County Parent.

"[Home visiting model] really helped me through navigating separation from an abusive marriage and encouraging me to do what I needed to do for myself and my daughter." ~ Garrett County Parent

"When they told me for the first time about the condition of (name of daughter), I felt that a bucket of cold water had fallen on me....I didn't know if she was going to be able to do the same things as other children her age...(name of home visitor) answered my questions related to my daughter's condition, and I could tell her my fears." ~ Baltimore

Evidence-Informed programs. Although the legislation charges the Maryland Workgroup on Newborn Home Visiting Services to focus on EBHV programs, evidence-informed programs also connect families with support and community resources they want and need. Evidence-informed home visiting programs are designed and adapted based on local community needs and lived expertise but have not yet met the HomVEE guidelines to receive an evidence-based designation. Some examples of evidence-informed home visiting models in Maryland include the Early Care Program, Healthy Start, and ParentChild+.

Worcester County's Early Care Program serves pregnant people and infants up to one year of age, with a focus on populations that have experienced domestic violence; lack of housing or transportation; alcohol or drug use; adolescent pregnancy or first-time pregnancy; or prenatal or postpartum depression. The Early

Care Program provides participants with educational supports and linkages to community resources based on need.³⁶

Maryland also offers two Healthy Start programs. Anne Arundel Healthy Start serves pregnant and postpartum people and children up to two years of age. The model is implemented by a team that includes a nurse, social worker, mental health therapist, and parent educator. Anne Arundel Healthy Start supports participants through case management services and linkages to community resources.³⁷

Baltimore City's Healthy Start Program is federally funded through the Maternal and Child Health Bureau's Healthy Start program and is available for pregnant people and caregivers, with services available until their child turns 18 months of age. Baltimore City Healthy Start provides family and adult education opportunities, parenting groups, and linkages to services to support health and wellbeing.³⁸

ParentChild+ is new to the Baltimore landscape, offering twice-weekly home visits from trained Early Learning Specialists who share a community connection with the families. The model focuses on cultural and linguistic alignment in hiring and supports native-born and immigrant populations to build foundations of school readiness, family engagement, and life-long learning. In addition to providing 1:1 support to families with children ages 16-48 months, the Early Learning Specialists also work with home-based child care programs to deliver the program to early educators, extending support to other key adults who are caring for children before kindergarten. Currently, the GreenLight Fund supports implementation for two Baltimore sites:—the New Song Learning Center and the Esperanza Center.

Lastly, other types of home visits are offered in Maryland, though they fall outside the scope of the four legislative charges. These additional home visits may be part of the state's early intervention program, Maryland Infants and Toddlers, and those offered to children with asthma and lead exposure. Some Judy Centers may offer home visits to families as part of their support services. Nurse midwives also provide home visits as part of clinical care, and doulas provide home visits as part of physical and emotional supports they deliver to pregnant and postpartum people. In addition, perinatal care coordination programs may offer home visiting depending on program capacity and client need, and service delivery depends on staff classifications.

Home Visiting Model Alignment. Home visiting model alignment allows jurisdictions to offer a mix of EBHV models to best meet the needs, priorities, and preferences of families. It also helps to increase awareness and formalize connections between models to assure successful transitions for families when appropriate. Some families might have all their needs met with a short-term universal EBHV model; other families might benefit from receiving additional, targeted support from a long-term EBHV program.

³⁶ 2023 Report on the Implementation and Outcomes of State-Funded Home Visiting Programs in Maryland.

³⁷ <https://www.aahealth.org/family-health/healthy-babies/healthy-start>

³⁸ <https://baltimorehealthystart.org/about-us/how-we-help/>

There are examples of EBHV model alignment in Maryland. For example:

- Workgroup member Erin Bonzon shared: “Howard County implements two nationally recognized, evidence-based home visiting models: Healthy Families America (HFA) and Parents as Teachers (PAT). Together, these programs operate under a unified umbrella that allows for a comprehensive, coordinated response to the diverse needs of families in Howard County.”
- Workgroup member Emma Cannon shared: “If an individual is interested in home visiting services, they are matched with a program based on eligibility criteria and openings. Data sharing of enrollment information through the [B’More for Healthy Babies] Care Coordination system allows HCAM to provide these home visiting referrals efficiently and prevent duplicate referrals.”
- Workgroup members Stacey Brown and Pilar Olivo highlighted the role that Family Connects (FC) plays in Baltimore City, Prince George’s County, and Frederick County as a complement to existing programs like HFA and PAT. FC offers a nurse home visit to all families, serving as an entry point for families seeking support. Arranged before hospital discharge, this initial visit when the baby is three weeks old introduces families to home visiting if it is new to them, and facilitates connections to longer-term programs such as HFA and PAT. An assessment is conducted to uncover the family’s unique strengths and needs, providing personalized referrals to additional support and services as needed. Lastly, FC acts as a second chance for families who may have previously declined participation in other home visiting during their pregnancy or are newly discovering long-term home visiting options.

Alignment between EBHV models and the perinatal and early childhood system of care further ensures home visitors are aware of locally available resources and enables them to connect families to the most appropriate supports. As guest speaker Monique Fountain Hanna reminded the Workgroup at the meeting on October 6, 2025, “Home visiting is part of a broader system of early childhood programs and services....to reach the aim of thriving children and families.”

Again, there are examples of EBHV model alignment with the broader perinatal and early childhood systems of care. For example:

- Workgroup member Erin Bonzon shared: “These [EBHV] programs are embedded into a system of care and support for children and families, within the County’s Department of Community Resources and Services’ Office of Children and Families which operates under a “no wrong door” approach to human services delivery. This structure ensures that families engaged with home visiting have seamless access to a broad network of programs and supports across the department and the wider community. This integrated model strengthens the impact of home visiting through a link to critical resources that promote overall family stability and well-being.”
- Workgroup member Delegate Jennifer White Holland shared: “There are a few Baltimore City and Baltimore County based entities that offer virtual and in-person home visiting services to Baltimore County families. The Baltimore

County Health Department has a range of perinatal programs, where providers use one form for referral. After the form is completed and submitted, Baltimore County Health Department reviews, triages, and makes the appropriate connections. Our health department serves as a central connection and referral point for families, where they can access internal and external programs and services.”

- Workgroup member Maria Friend shared: “In Garrett County, Early Care Programs System of Care is a comprehensive primary prevention service delivery modality that was created to ensure all Garrett County children are healthy and enter school ready to learn. Early Care Program unit’s system of care serves as a centralized intake unit for family support programs throughout the jurisdiction. The program provides one single point of entry for access, assessment, and referral to local family support services for expecting families and families with newborns who reside in Garrett County. “

Overall, alignment within EBHV models and across systems helps improve access to services, fosters better outcomes for children and families, and reduces the stress families experience when navigating complex, fragmented systems.

Funding Evidence-Based Home Visiting in Maryland. In addition to information gleaned from Maryland's FY 26 state budget, the 2023 Report on Implementation and Outcomes of State-Funded Home Visiting Programs in Maryland also reports funding sources that support home visiting.

Maternal, Infant and Early Childhood Home Visiting. The MIECHV program funds 19 home visiting programs across 17 jurisdictions that implement HFA and NFP.³⁹ Approximately 1,086 families received home visiting services from programs funded through MIECHV in Federal FY 2024 (see Table 6). In FY 2025, the Health Resources and Service Administration awarded Maryland a total of \$10,518,799 in MIECHV funds.⁴⁰

Medicaid. Maryland Medicaid provides reimbursement to home visiting providers that implement home visiting services for birthing parents and children participating in Medicaid. HFA and NFP are currently the only two models approved for Medicaid’s home visiting service coverage,⁴¹ with twelve HFA sites and two NFP sites currently enrolled as Medicaid providers. In 2023, Medicaid reimbursed home visiting services delivered to over 600 unique individuals, including more than 200 infants.⁴²

³⁹ Correspondence with Maryland MIECHV, 06/26/2025.

⁴⁰ <https://mchb.hrsa.gov/programs-impact/programs/home-visiting/maternal-infant-early-childhood-home-visiting-miechv-program/fy25-awards>

⁴¹ <https://health.maryland.gov/mmcp/medicaid-mch-initiatives/Documents/HVS/HVS%20FAQs-8.2.24.pdf>

⁴² Committee testimony for SB0156, Maryland Department of Health.

Office of Head Start. The Office of Head Start within the US HHS Office of the Administration for Children and Families also supports implementation of Early Head Start home-based programs in Maryland. As of summer 2025, seven EHS home-based programs, either operating as home-based only or co-located with center-based programs, supported eight jurisdictions.

Maryland State Department of Education. As of summer 2025, MSDE funds 17 home visiting programs across 17 jurisdictions and supports the implementation of HFA, HIPPY and PAT.⁴³ Approximately 907 families received home visiting services from programs funded by MSDE in 2025 (see Table 6). For FY26, MSDE's Healthy Families Home Visiting Grant Program will contribute \$4,590,667 towards home visiting implementation in Maryland, providing grantees with awards ranging from \$55,000 - \$350,000.⁴⁴

Children's Cabinet Interagency Fund. CCIF funds support the implementation of HFA, HIPPY, PAT, and NFP models in eight jurisdictions.⁴⁵

Respondents to the 2023 state-funded home visiting survey reported receiving funds from other federal grants such as the Community-Based Child Abuse Prevention grant and Title V Maternal and Child Health Services Block Grant but did not disclose funding amounts. Similarly, we do not know the amount of local or philanthropic funds that support implementation of EBHV programs in Maryland.

⁴³Correspondence with MSDE, 07/18/2025.

⁴⁴ <https://marylandpublicschools.org/programs/Pages/Special-Education/rmmb/Grants/HomeVisiting/index.aspx>

⁴⁵ Correspondence with Governor's Office for Children, 07/21/2025.

Table 6. Families Enrolled in Maryland Home Visiting by Model, Funded by MIECHV (FY 24) and MSDE (FY 25)

Jurisdiction	Home Visiting Models	MIECHV	MSDE
Allegany	HFA	48	--
	PAT	--	25
Anne Arundel	--	--	--
Baltimore City	HFA	261	193
	NFP	201	--
Baltimore County	HFA	84	90
Calvert	HFA, HIPPY, PAT	--	13
Caroline	HFA	See Queen Anne's	--
Carroll	--	--	--
Cecil	HFA	20	--
Charles	HFA	--	17
Dorchester	HFA	39	45
Frederick	HFA	--	54
Garrett	HFA	54	65
Harford	HFA	27	--
Howard	HFA	--	27
Kent	HFA	See Queen Anne's	15
Montgomery	HFA	--	73
Prince George's	HFA	122	21
Queen Anne's	HFA	40	42
Somerset	HFA	6	49
St. Mary's	NFP	47	--
Talbot	HFA	32	42
Washington	HFA	73	73
Wicomico	HFA	32	63
Worcester	--	--	--
Maryland		1086	907

Sources. ¹The Maternal, Infant and Early Childhood Home Visiting (MIECHV) data provided is for Federal Fiscal Year 2024, 10/1/2023 – 9/30/2024 and represents MIECHV grantees.

²The Maryland State Department of Education data provided is for Fiscal Year 2025, 7/1/2024 – 6/30/2025 and represents Healthy Families grantees.

Note. – There are no home visiting program sites in this county funded by MIECHV and/or MSDE.

Anne Arundel County has an Early Head Start home-based program administered by MSDE and funded through the Office of Head Start.

The Healthy Families Midshore program serves families in Caroline, Kent, and Queen Anne Counties and reports participant counts for all three counties combined.

Staffing Evidence-Based Home Visiting in Maryland. The MDH 2023 Report on the Implementation and Outcomes of State-Funded Home Visiting Programs⁴⁶ indicates that 41 sites reported that they employed approximately 199 full-time equivalent (FTE) home visitors. 90% of the home visitors are female, 28% are between 30-39 years old, 14% are Hispanic or Latino, 41% are Black or African American, and 34% have a bachelor's degree.

The Maryland Hospital Association commissioned a nursing workforce study that issued projections for 2021-2035.⁴⁷ That study found a current and growing shortfall of nurses estimated at 5,000 registered nurse (RN) FTE and 4,000 licensed practical nurse (LPN) FTE in 2021, meeting only 91% of RN demand and 69% of LPN demand based on a national average standard of nursing care. By 2035, the shortage is projected to grow to 13,800 RN FTE and 9,200 LPN FTE, meeting only 80% of anticipated RN demand and 44% of projected LPN demand. All regions across the state are projected to have a shortage except the central region (including Baltimore City and County) where RN supply is projected to be adequate to meet demand.

The 2024 National Nursing Workforce Survey shared Maryland age, gender and ethnicity data related to the RN workforce. It notes that 45% of MD RNs are more than age 55, 91% are female, and 66% are white, 20% are Black, and 6% are Asian. 18% have a bachelors' and 48% have a master's degree.⁴⁸

Laura Allen, Assistant Professor, Department of Family and Community Health, University of Maryland School of Nursing (UMSON) shared with the Workgroup that currently, UMSON does not have any clinical sites for either undergraduate or nurse practitioner students that engage in newborn home visiting programs.

The home visiting workforce in general, and nurses in particular, were negatively impacted by the COVID-19 pandemic. It is widely reported that decreased morale, increased burnout and turnover contribute to stress on the profession. Pay that does not match a livable wage further exacerbates the challenge.

With respect to training on cultural responsiveness, all EBHV models host their own workforce training programs, and they include cultural responsiveness as a required and fundamental part of their training. In additional, free, supplementary training on a range of topics including cultural and linguistic responsiveness is available for home visitors through the Institute for the Advancement of Family Support Professionals.⁴⁹ For nursing students, cultural responsiveness is a topic included in all undergraduate and graduate programs at UMSON. As part of their license renewal,

⁴⁶ https://dlslibrary.state.md.us/publications/Exec/MDH/HU8-507%28c%29_2023.pdf

⁴⁷ <https://mhaonline.org/wp-content/uploads/2024/01/Maryland-Nurse-Workforce-Projections-GlobalData.pdf>

⁴⁸ [https://www.journalofnursingregulation.com/article/S2155-8256\(25\)00047-X/fulltext](https://www.journalofnursingregulation.com/article/S2155-8256(25)00047-X/fulltext)

⁴⁹ <https://institutefsp.org/>

nurses were required to complete a one-time training in implicit bias and structural racism.⁵⁰

Recommendations

The Workgroup offers the following recommendations as aspirational goals to ensure every Maryland child and family has a strong start. It acknowledges the current economic challenges in the state and the need for next-level conversations on critical topics including home visiting finance, workforce expansion, and phased implementation, beginning in jurisdictions that demonstrate the most need and are ready for expansion. This set of recommendations needs to build upon what already exists in the state and individual communities to reinforce a perinatal and early childhood system of care that supports every family.

Infrastructure to Support Universal Home Visiting

The Workgroup recommends that Maryland study the feasibility and potential benefits of developing a centralized intake and referral process, along with a related data system, to strengthen coordination of home visiting within the perinatal and early childhood system. The assessment should look at how these tools could increase awareness of services, build on existing relationships with trusted community voices, reach families at key moments in their care for engagement in services, make it easier for families to access services, reduce duplication across programs, and improve follow-up through closed-loop referrals.⁵¹ It should also consider how a shared data system could support consistent data collection and reporting on outcomes and equity for ongoing quality improvements. Any future approach should build on existing local systems and resources, allow for flexibility to meet local needs, and include ways to track and reduce participation and outcome gaps.

Key elements of the infrastructure include:

- **Centralized Intake and Referral:** Support exploration of a statewide centralized intake and referral that serves as a “one front door” for all families and is accessible to all partner agencies. Each jurisdiction should identify their “hub” responsible for centralized intake and referral (e.g., local health departments, existing Thrive by Three and Babies Born Healthy systems). Centralized intake and referral should include:
 - Awareness, Outreach, and Engagement of Families
 - Raise awareness of universal home visiting services, conduct outreach to organizations and services trusted and used by pregnant and parenting families, and coordinate direct engagement with families at key prenatal and postpartum

⁵⁰ <https://health.maryland.gov/optometry/Documents/hb783.pdf>

⁵¹ Closed-loop referral means a process by which individuals receive the necessary follow-up care after being referred to another service, system, or provider.

- education, and other community programs including jurisdictional hubs
- Use shared consent forms
- Incorporate data from mPRA and PIMR
- Use standardized measures and common data fields
- Include a public equity dashboard that tracks home visiting reach and outcomes by race, zip code, payer, and county
- Make data publicly available to ensure transparency and accountability
- Prompt regular review to assess completion rates, family satisfaction, and services outcomes, gaps, duplication as well as opportunities for improvement

Alignment to Maximize Efficiency and Minimize Duplication

The Workgroup recommends that Maryland create a home visiting continuum within the perinatal and early childhood system of care that provides seamless access for all families at the community level to access the most appropriate home visiting model and other supports. Alignment and integration will help to maximize efficiency and minimize duplication within home visiting and across the health, education, and social service sectors.

Key elements include:

- **Alignment and Integration Across Home Visiting Models.** Jurisdictional “roadmaps” can help improve coordination between short- and long-term evidence-based home visiting models, enabling families to be connected to the approach that most closely matches their needs and preferences. Roadmaps would build on existing state and local needs and gaps analysis, and include plans for program implementation, quality improvement, financing, and sustainability. They would be driven by a commitment to realizing the universal + targeted vision of home visiting and by ensuring access and equity.
- **Alignment and Integration Across Existing Systems.** Leverage and build on current perinatal and early childhood systems of care including at a minimum those operating out of the Maryland Department of Health (e.g., mPRA, PIMR, Thrive by Three, Babies Born Healthy, WIC, and Medicaid), the Maryland State Department of Education (e.g., Judy and Patty Centers, Early Head Start), the Maryland Department of Human Services (e.g., SNAP), and other state-wide programs and initiatives such as the Enough Act Communities.

Universal + Targeted Home Visiting for Maryland Families

The Workgroup recommends that Maryland implement a voluntary, statewide, universal nurse home visiting program that builds upon existing evidence-based home visiting efforts and is designated as an “evidence-based” home visiting program by the US Department of Health and Human Services. This program should ensure that every family is offered, at minimum, a voluntary nurse home visit shortly after birth, excluding families who are already participating in a nurse home visiting model. Families who need additional support would be referred to more intensive,

evidence-based home visiting and other programs and services tailored to their individual needs and preferences.

Key elements include:

- **Population-Level Impact:** Offer home visiting options prenatally to parents before the scheduled birth or due date. Offer voluntary, universal, short-term nurse home visits to all newborns in the state. Include evidence-based best practices in all forms of home visiting (e.g., lactation support) and ensure communication between the home visitor and health care providers for the parent and child.
- **Equitable Access:** Complement existing programs and ensure equitable access by prioritizing jurisdictions with high poverty, poor birth outcomes, or no birthing hospitals to address disparities.
- **Flexible Service Options:** Expand—not replace—effective offerings in each jurisdiction including the range of programming and support provided by home visitors and community birth workers (e.g., midwives, doulas, lactation specialists, community health workers). Maintain effective programs and add both short-term and longer-term targeted service options to meet diverse family needs and build on community assets.

This recommendation seeks to build a system in which all families are offered timely support if they choose, with the goal of improving birth and maternal health outcomes and enhancing Maryland's perinatal and early childhood system of care

Home Visiting Workforce

The Workgroup recommends investing in comprehensive strategies to grow and support the home visiting workforce to achieve the goal of universal + targeted home visiting. Partnerships with higher education institutions, hospitals, and community organizations should be leveraged to create diverse pathways into the field and ensure staff are well-prepared and supported. Prioritizing cultural responsiveness through ongoing training, recruitment from within served communities, and interpreter services will help build trust and effectively engage families. Competitive compensation, flexible work arrangements, and mental health support are also critical to maintaining a committed and culturally responsive workforce.

Key elements include:

- **Staffing**
 - **Create a Pipeline for Home Visitors:** Collaborate with institutions of higher education and birthing hospitals to explore strategies needed to address the home visiting workforce gap that aligns with the phased implementation of universal + targeted home visiting. Explore this from the understanding that home visitors come from a variety of fields including but not limited to early childhood education, social work, and nursing. Ensure that traditional education is paired with clinical or practice experience for all those planning to assume a home visitor role, regardless

- of the field of study or home visiting model. For nurse EBHV models, the staff pathway is through a formal nursing degree. For other EBHV models, alternative pathways for identifying and training staff may be appropriate. All home visitors, regardless of their training, need relational competencies to effectively build trust and engage families.
- **Expand Nurse-Led and Multilingual Teams:** Explore how nurse-led teams can be supported with other health-focused and bilingual staff to ensure equitable access and cultural responsiveness of nurse home visiting programs. Given the current RN shortage, explore supplementing teams with LPNs, community health workers, lactation consultants or counselors, medical assistants, and other non-clinical staff who can support the home visiting model.
 - **Innovative Employer Partnerships:** Encourage innovative partnerships between home visiting programs and hospitals and health care providers employing nurses to enable shared or part-time staffing models for home visiting.
- **Training**
 - **Cultural Responsiveness:** Provide ongoing cultural responsiveness training that complements and extends what is typically required by the home visiting national models and nursing programs. Encourage staff recruitment within communities being served so that home visitors understand the cultural context and can engage families in their first language. Provide interpreter services as needed.
 - **Ongoing Supplemental Training:** Offer ongoing supplemental training that complements the training that is required by home visiting national models and ensures all home visitors master relationship-based competencies and are delivering services that reflect best practice.
 - **Cross-Sector Training:** Cross-sector training opportunities (e.g., between home visiting and early childhood education, and behavioral health) should be created to help ensure sustainability and alignment across Maryland's broader perinatal and early childhood system of care.
 - **Recruitment and Retention**
 - **Recruitment and Retention:** Develop strategies for workforce recruitment and retention, that includes but is not limited to scholarship opportunities for nurses who commit to delivery home visiting services in the state after graduation, loan forgiveness opportunities for home visitors who have already completed their education, competitive salaries, benefits, flexible hours/schedules, reflective supervision, and support for the mental health of the workforce.

Financing and Resource Needs

The Workgroup recommends that Maryland pursue several strategies over time to secure sustainable financing and resources to support universal + targeted home visiting, along with the necessary infrastructure. Achieving long-term sustainability will require a phased implementation approach that preserves and builds upon existing efforts. This process should include developing a comprehensive funding

plan, designating a permanent financing source, leveraging a mixed-payer system, and ensuring flexibility to meet local needs. Ultimately, financing solutions must be equitable, adaptable, and compliant with Maryland statutes.

Key elements include:

- **True cost of a Universal + Targeted Home Visiting:** Convene state agencies (e.g., Maryland Department of Health, Medicaid, Maryland State Department of Education, Maryland Department of Human Services), private insurers, home visiting model representatives, and community leaders to:
 - conduct further research to understand the true cost of service delivery for universal + targeted home visiting and the related infrastructure costs (e.g., for central intake, data system, state governance and leadership, local hubs for systems coordination),
 - explore sustainable financing models, including new sources of funding so to not draw resources away from current investments
 - determine what costs can be phased in, and what are essential for state-wide implementation
 - define a plan for supporting existing local efforts as demonstration sites to better understand true costs and deepen alignment across home visiting models and the perinatal and early childhood system to continuously improve efficiency for broader application as resources are available.
- **Maternal and Child Health Population Health Improvement Fund:** Designate (with adjustments for inflation) the Maternal and Child Health Population Improvement Fund as a permanent financing sources to sustain and expand investments in EBHV, community-based doula services, CenteringPregnancy (group care), Maternal Opioid Model Program, and other efforts. Since 2021, the Fund has supported Medicaid-covered benefits and public health programs, delivered by local health departments and community-based organizations, expanding access to EBHV models statewide and demonstrating improvements in prenatal care initiation, immunization rates, and well-child visits. Marking this funding permanent will sustain these proven home visiting programs and strengthen the state's broader maternal and child health priorities.
- **Mixed-Payer System:** Prioritize development of a mixed-payer approach, intentionally braiding private insurance, state, federal, and philanthropic funds to ensure no out-of-pocket cost for families. Design the system so that it can be implemented flexibly to meet the needs and challenges of local communities and build upon their strengths and assets. Explore adding EBHV with documented health care outcomes to the Maryland Insurance Administration's list of Mandated Benefits.
- **Flexible Payment Models:** Use capitation, per-birth bundles, or cases rates to reimburse service delivery for programs that are meeting defined metrics. Explore value-based payment models that reward improved maternal and child health outcomes, as well as leveraging hospital community benefit dollars, private insurance, and Managed Care Organization partnerships to support early home visiting as a preventive service.

- **Start-Up or Capacity-Building Grants:** Offer start-up or capacity-building grants for local jurisdictions to fund readiness, infrastructure, workforce capacity, and cross-program coordination, as part of phased implementation
- **Periodic Rate Setting:** Establish a state-wide rate setting committee and process to engage in periodic data review and rate-setting to ensure full cost recovery and long-term sustainability.

Public Awareness

The Workgroup recommends the development and phased implementation of a marketing and outreach campaign to raise awareness about the opportunity for voluntary universal + targeted home visiting, ensuring families understand how these services can benefit them and providing clear guidance on how to enroll. This campaign should be tailored to each community to ensure responsiveness to cultural and language needs, and it must leverage trusted messengers to build credibility and engagement. Additionally, the strategy should align with the phased rollout of the overall expansion of voluntary universal + targeted home visiting across the state.

Key elements include:

- **Message Development and Collateral:** Develop clear, simplified, non-stigmatizing and culturally responsive messages and related collateral about the benefits of home visiting and how to enroll. Messages will need to vary based on local culture and within cultural sub-groups to ensure the campaign reaches and resonates with all Maryland families in their primary languages. Collateral should also be tailored to the formats found to be most effective in each jurisdiction (e.g., flyers, QR codes, social media ads). Sharing real stories from parents who have benefited from home visiting can make messaging more relatable and authentic.
- **Proactive Strategies and Tactics:** Consider engaging a myriad of partners who represent trusted voices in the community to share the message about the value of home visiting for every family.
 - Parents - Empower and support current families to be home visiting ambassadors, helping to spread the word.
 - Community Partners – Ensure that WIC offices, Judy and Patty Centers, houses of worship, and other local places where families gather share information about home visiting and how to sign up for services.
 - Health Providers - Support health providers – obstetricians, pediatricians, family physicians, midwives, doulas, nurses, community health workers, lactation consultants, birthing hospitals, and more -- to raise awareness of the benefits of home visiting and talk with parents during prenatal visits, bedside post birth, and during newborn well visits about connecting to the universal + targeted home visiting programs.
 - Insurers and Hospitals - Collaborate with insurers and hospitals to communicate with patients about their eligibility for universal home visiting.

Governance and Leadership

The Workgroup recommends the activation of a cross-sector leadership coalition that integrates state agencies, local health departments, hospitals, and family representatives. This coalition should oversee development of the expanded perinatal and early childhood system of care to include universal + targeted evidence-based home visiting, alignment within home visiting and across state departments and programs, and phased implementation, ensuring consistent standards and minimizing duplication. Families, home visitors, and health care providers should be included in the leadership structure, participating in the planning, design, implementation, and evaluation. Regional hubs will support local adaptation and statewide consistency. Dedicated funding, resources, and support for these governance and leadership proposals is essential. Together, these recommendations represent a cohesive, accountable, and family-centered governance model.

Key elements include:

- **Family and Home Visitor Voice and Leadership:** Ensure family members and home visitors have meaningful roles in all aspects of the planning, design, implementation and evaluation of universal + targeted home visiting and how it interfaces with the perinatal care and early childhood education systems. Family and home visitor voice and leadership should happen at all levels of the system from the state to regional, and jurisdictional. Families should be compensated for their participation.
- **Cross-Sector Leadership Coalition:** Form a governance body that “owns” this work including the Maryland Department of Health, Medicaid, Maryland Insurance Administration, local health departments, Maryland Hospital Association and birthing hospitals, Maryland State Department of Education, Maryland Department of Human Services, the Governor’s Office for Children, family representatives, home visiting staff and advocates, and community leaders. The responsibilities would include overseeing the infrastructure, policy, coordination, data-sharing, phased implementation and timelines, regulatory and rate reviews, and accountability of home visiting nested within the perinatal and early childhood system of care. They would also potentially include overseeing supplemental training that complements the training required by home visiting national models, ensuring that all home visitors master relationship-based competencies and deliver services that reflect best practice, as well as cross-sector training. Dedicated resources will be needed for this coalition to convene and conduct their work.
- **State-Level Staffing Capacity:** Expand staffing and resources within the Maryland Department of Health, the Maryland State Department of Education, and the Maryland Department of Human Services to work together to coordinate phased implementation, evaluation, quality improvement, technical assistance, and planning for scale of universal + targeted home visiting in alignment with other state resources. State-level staff would provide oversight and guidance to the regional hubs, and use learnings from local implementation to continuously improve the overall

support for home visiting expansion in the state as a component of the perinatal and early childhood system of care.

- **Regional Hubs:** Provide funding, guidance, and support to jurisdictions to form regional hubs that will be responsible for creating a local roadmap for the universal + target home visiting programs in their jurisdiction. Roadmaps would build on existing state and local needs and gaps analysis, and include plans for phased implementation, quality improvement, financing, and sustainability. Ensure regional hubs include parent representatives and interface with a variety of local maternal and child health service providers, including medical providers, home visiting staff, and other key stakeholders.

Phased Implementation

To move these recommendations from concept into practice, it is suggested that the Cross-Sector Leadership Coalition adopt a structured approach that allows for thoughtful planning, testing, and scaling. This may include efforts informed by exercises such as an Impact-Effort Matrix, where home visiting strategies are prioritized by comparing their potential impact on Maryland families with the level of resources or effort required for implementation. In addition, these overall recommendations can be operationalized and guided using frameworks such as Active Implementation Stages, to help organize the necessary steps across four phases: Exploration, Installation, Initial Implementation, and Full Implementation. This particular framework requires the engagement of partners throughout all stages and realistically will take at least 3 to 5 years to scale these recommendations statewide. An intentional and phased implementation approach ensures that these strategies are introduced with readiness, refined through pilot learning, and expanded statewide with sustainability and fidelity in mind. It is important to note that the phased implementation of any and/or all recommendations cited in this report is contingent upon several factors, including adequate and dedicated fiscal and personnel resources.

Conclusion

Maryland stands at a pivotal crossroads, equipped with the insights of families, practitioners, and leaders who have voiced a clear and urgent call: every child and family deserves a strong, equitable start. The Workgroup's recommendations reflect both aspiration and pragmatism -- recognizing the state's economic realities while charting a path toward universal + targeted home visiting that begins prenatally and extends through early childhood. By investing in robust infrastructure, aligning and expanding evidence-based home visiting programs, and centering the lived expertise of families, Maryland can create a seamless continuum of perinatal and early childhood care that supports lifelong well-being.

The journey ahead will require sustained commitment, phased implementation, and ongoing collaboration between public and private partners at the state and local

levels. As Maryland moves forward, it must remain steadfast in its dedication to equity, transparency, and continuous improvement -- ensuring that every family, regardless of zip code or circumstance, has access to the support they need to thrive. By embracing this vision, Maryland can fulfill its promise to its youngest residents and set a standard for comprehensive, family-centered care.

Appendix

Appendix A: Abbreviations

Appendix B: Tables

Appendix C: Workgroup Meeting Agendas

Appendix A. Abbreviations

ABC	Attachment Biobehavioral Catch-up
ALICE	Asset Limited, Income Constrained, Employed
CCIF	Governor's Office for Children's Cabinet Interagency Fund
CCP	Care Coordination Program
CCS	Child Care Scholarship
CRISP	Chesapeake Regional Information System for our Patients
DHS	Maryland Department of Human Services
EBHV	Evidence-based Home Visiting
EHS	Early Head Start home-based option
FC	Family Connects
FPL	Federal Poverty Level
FTE	Full-time Equivalent
FY	Fiscal Year
HCAM	Health Care Access Maryland
HFA	Healthy Families America
HIPPY	Home Instruction Program for Preschool Youngsters
HomVEE	Home Visiting Evidence of Effectiveness
JHU	Johns Hopkins University
LPN	Licensed Practical Nurse
MDH	Maryland Department of Health
MDMOM	Maryland Maternal Health Innovation Program
MECSH	Maternal Early Childhood Sustained Home-visiting Program
MFN	Maryland Family Network
MIECHV	Maternal, Infant, and Early Childhood Home Visiting
MIHOW	Maternal Infant Health Outreach Worker Program
MOM	Maternal Opioid Misuse
mPRA	Prenatal Risk Assessment
MSDE	Maryland State Department of Education
NFP	Nurse Family Partnership
NSCH	National Survey of Children's Health
OB	Obstetrics
PAT	Parents as Teachers
PIMR	Postpartum Infant Maternal Review
RN	Registered Nurse
SMM	Severe Maternal Mortality
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families
TCA	Temporary Cash Assistance
UMSON	University of Maryland School of Nursing
US	United States
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

Appendix B. Tables

Table B-1. Population of Children Under Age 5 Years in Maryland by Race and Ethnicity, by Jurisdiction, 2023

Jurisdiction	AI and AN Alone (%)	Asian Alone (%)	Black/African American Alone (%)	NH and OPI Alone (%)	White Alone (%)	Some Other Race Alone (%)	Two or More Races (%)	Hispanic or Latino (%)
Allegany	0 (0.0)	8 (0.3)	110 (3.5)	0 (0.0)	2,658 (85.7)	7 (0.2)	317 (10.2)	97 (3.1)
Anne Arundel	253 (0.7)	996 (2.8)	6,244 (17.5)	4 (0.0)	19,613 (54.9)	2,126 (5.9)	6,510 (18.2)	6,324 (17.7)
Baltimore City	35 (0.1)	548 (1.6)	20,270 (57.4)	0 (0.0)	7,792 (22.1)	3,107 (8.8)	3,553 (10.1)	5,807 (16.4)
Baltimore County	51 (0.1)	3,341 (6.8)	16,585 (33.7)	9 (0.0)	20,255 (41.1)	3,418 (6.9)	5,595 (11.4)	7,482 (15.2)
Calvert	6 (0.1)	5 (0.1)	400 (8.1)	12 (0.2)	3,492 (70.9)	101 (2.1)	909 (18.5)	353 (7.2)
Caroline	87 (4.2)	0 (0.0)	297 (14.3)	0 (0.0)	1,277 (61.4)	79 (3.8)	341 (16.4)	427 (20.5)
Carroll	4 (0.0)	178 (1.9)	325 (3.4)	0 (0.0)	7,859 (82.3)	186 (1.9)	995 (10.4)	739 (7.7)
Cecil	0 (0.0)	155 (2.6)	298 (5.0)	0 (0.0)	4,406 (74.2)	18 (0.3)	1,058 (17.8)	548 (9.2)
Charles	23 (0.2)	229 (2.3)	4,822 (49.4)	0 (0.0)	2,679 (27.4)	468 (4.8)	1,542 (15.8)	1,346 (13.8)
Dorchester	0 (0.0)	0 (0.0)	551 (31.5)	0 (0.0)	810 (46.3)	127 (7.3)	263 (15.0)	223 (12.7)
Frederick	25 (0.2)	818 (4.9)	1,994 (12.0)	8 (0.0)	9,993 (60.1)	695 (4.2)	3,087 (18.6)	3,241 (19.5)
Garrett	0 (0.0)	2 (0.2)	0 (0.0)	0 (0.0)	1,215 (91.4)	11 (0.8)	102 (7.7)	30 (2.3)
Harford	33 (0.2)	261 (1.8)	2,009 (14.0)	0 (0.0)	9,459 (65.9)	540 (3.8)	2,047 (14.3)	1,249 (8.7)
Howard	131 (0.7)	2,760 (14.9)	3,731 (20.2)	0 (0.0)	7,337 (39.7)	1,116 (6.0)	3,421 (18.5)	2,655 (14.4)
Kent	0 (0.0)	3 (0.4)	184 (23.6)	0 (0.0)	473 (60.6)	84 (10.8)	36 (4.6)	88 (11.3)
Montgomery	456 (0.7)	6882 (11.2)	11,387 (18.5)	12 (0.0)	21,818 (35.4)	9,698 (15.7)	11,324 (18.4)	18,465 (30.0)
Prince George's	312 (0.5)	1,744 (2.9)	29,668 (49.9)	0 (0.0)	6,675 (11.2)	14,562 (24.5)	6,473 (10.9)	21,034 (35.4)
Queen Anne's	0 (0.0)	6 (0.2)	69 (2.6)	0 (0.0)	2,008 (76.3)	163 (6.2)	386 (14.7)	317 (12.0)
Somerset	43 (0.6)	90 (1.3)	998 (14.3)	0 (0.0)	4,483 (64.1)	194 (2.8)	1,189 (17.0)	653 (9.3)
St. Mary's	0 (0.0)	0 (0.0)	352 (30.7)	0 (0.0)	503 (43.8)	21 (1.8)	272 (23.7)	131 (11.4)
Talbot	15 (0.9)	33 (2.1)	282 (17.8)	0 (0.0)	1,089 (68.7)	47 (3.0)	120 (7.6)	208 (13.1)
Washington	7 (0.1)	135 (1.6)	1,055 (12.3)	0 (0.0)	5,612 (65.5)	156 (1.8)	1,606 (18.7)	1,192 (13.9)
Wicomico	0 (0.0)	57 (0.9)	2,258 (36.1)	0 (0.0)	2,927 (46.7)	264 (4.2)	755 (12.1)	849 (13.6)
Worcester	0 (0.0)	0 (0.0)	236 (11.0)	0 (0.0)	1,528 (71.0)	50 (2.3)	338 (15.7)	173 (8.0)
Maryland	1,481 (0.4)	18,251 (5.1)	104,125 (29.0)	45 (0.0)	145,961 (40.6)	37,238 (10.4)	52,239 (14.5)	73,631 (20.5)

Source: Sex by Age. US Census Bureau, B01001 series, 2019-2023 American Community Survey 5-Year Estimates. Race and ethnicity categories match those provided by the US Census. AI and AN: American Indian and Alaskan Native; NH and OPI: Native Hawaiian and Other Pacific Islander. Survey respondents can choose a race and separately select ethnicity. Hispanic or Latino category includes those who identify as Hispanic, Latino, or Spanish and may be of any race.

Table B-2. Population of Children Under Age 6 Years in Maryland Living in Poverty by Jurisdiction, 2023

Jurisdiction	Percent of Children Under 6 Living in Poverty	Number of Children Under 6 Living in Poverty	Total Children Under 6
Allegany	22.1	867	3,926
Anne Arundel	5.4	2,294	42,179
Baltimore City	26.2	10,977	41,834
Baltimore County	13.9	8,045	57,769
Calvert	3.5	209	6,045
Caroline	26.4	642	2,430
Carroll	4.8	555	11,591
Cecil	17.3	1,224	7,064
Charles	7.4	819	11,141
Dorchester	24.7	494	1,999
Frederick	7.6	1,515	19,882
Garrett	9.2	150	1,626
Harford	8.8	1,528	17,334
Howard	6.3	1,381	21,973
Kent	4.1	40	981
Montgomery	9.1	6,606	72,279
Prince George's	13.0	9,011	69,138
Queen Anne's	6.5	210	3,224
Somerset	9.8	844	8,627
St. Mary's	26.3	356	1,354
Talbot	12.6	254	2,018
Washington	17.5	1,825	10,438
Wicomico	21.8	1,644	7,541
Worcester	15.1	369	2,440
Maryland	12.2	51,859	424,833

Source: Poverty Status in the Past 12 Months by Age. US Census Bureau, B17020, 2019-2023 American Community Survey 5-Year Estimates.

Table B-3. Selected Birth and Death Outcomes in Maryland by Jurisdiction, 2023

Jurisdiction	Total Births¹	Inadequate Prenatal Care¹ (% of births with late or no prenatal care)	Low Birth Weight¹ (% live born infants <2500 g)	Preterm Birth¹ (% infants born <37 weeks)	Infant Mortality Rate, 2023¹ (Deaths per 1,000 live births)	Infant Mortality Rate, 2019-2023² (Deaths per 1,000 live births)
Allegany	596	4.1	11.2	11.7	**	10.9
Anne Arundel	6,556	4.4	7.4	9.5	4.3	4.8
Baltimore City	6,930	9.2	11.7	11.8	8.8	8.7
Baltimore County	8,849	5.5	9.6	11.3	5.9	6.4
Calvert	867	4.9	6.1	9.3	**	4.7
Caroline	380	7.8	11.1	10.5	**	**
Carroll	1,639	4.2	6.0	8.4	**	3.3
Cecil	1,200	4.7	6.8	9.8	**	6.8
Charles	1,731	8.0	9.2	10.5	**	6.5
Dorchester	376	5.4	10.6	13.0	**	**
Frederick	3,176	4.7	6.6	8.8	**	3.7
Garrett	251	**	**	8.0	5.2	**
Harford	2,628	2.9	7.6	10.1	**	4.4
Howard	2,937	5.3	8.1	10.3	**	4.9
Kent	153	**	**	**	**	**
Montgomery	10,896	8.1	7.3	9.0	4.0	4.5
Prince George's	10,583	12.8	9.4	10.9	7.5	7.1
Queen Anne's	558	6.1	6.1	9.5	**	**
Somerset	251	**	9.2	8.4	**	**
St. Mary's	1,318	6.8	5.7	8.5	**	5.5
Talbot	338	**	10.1	9.8	**	**
Washington	1,589	6.6	9.8	10.1	**	6.8
Wicomico	1,359	9.3	9.7	11.1	**	7.5
Worcester	417	9.2	7.2	8.2	**	**
Maryland	65,578	7.4	8.6	10.2	5.7	5.9
United States^{3,4}	3,596,017	7.0	8.6	10.4	5.6	--

Notes. **Percentages or rates based on <20 events are not presented since such percentages or rates are subject to instability. ¹Maryland Department of Health, Maryland Vital Statistics Annual Report 2023. ²Maryland Vital Statistics [Infant Mortality](#), 2023. March 2025. ³Osterman MJK, Hamilton BE, Martin JA, Driscoll AK, Valenzuela CP. Births: Final data for 2023. National Vital Statistics Reports; vol 74, no 1. Hyattsville, MD: National Center for Health Statistics. 2025.

Table B-4. Care Coordination Initiatives by Jurisdiction

Jurisdiction	Care Coordination Initiative
Allegany	N/A
Anne Arundel	Babies Born Healthy
Baltimore City	Babies Born Healthy Health Care Access Maryland—Connector Program Thrive by Three
Baltimore County	Babies Born Healthy
Calvert	N/A
Caroline	Babies Born Healthy
Carroll	N/A
Cecil	N/A
Charles	Babies Born Healthy
Dorchester	N/A
Frederick	Thrive by Three
Garrett	N/A
Harford	Thrive by Three
Howard	N/A
Kent	N/A
Montgomery	Babies Born Healthy
Prince George's	Babies Born Healthy
Queen Anne's	N/A
Somerset	Thrive by Three
St. Mary's	N/A
Talbot	N/A
Washington	N/A
Wicomico	Babies Born Healthy Thrive by Three
Worcester	N/A

Sources: Health Care Access Maryland. <https://www.healthcareaccessmaryland.org/>
Maryland Department of Health, Maternal and Child Health Bureau Perinatal Care
Coordination. <https://health.maryland.gov/phpa/mch/Pages/Perinatal-Care-Coordination.aspx>

Table B-5. Outcomes of Evidence-based Home Visiting Models in Maryland†

	Child Development and School Readiness	Child Health	Family Economic Self-Sufficiency	Linkages and Referrals	Maternal health	Positive Parenting Practices	Reductions in Child Maltreatment*	Reductions in Juvenile Delinquency, Family Violence, and Crime
ABC								
EHS								
FC								
HFA								
HIPPY								
NFP								
PAT								

*Outcomes must meet definitions outlined by the US Department of Health and Human Services Home Visiting Evidence of Effectiveness (HomVEE) guidelines. For the *Reductions in Child Maltreatment* outcome domain, HomVEE includes only substantiated reports of child maltreatment and child welfare measures such as custody loss and placement outside the home; outcome measures based on unsubstantiated reports are ineligible for review. Source: <https://homvee.acf.gov/>

†Models active in Maryland prior to 2025.

Table B-6. Eligibility Requirements of Evidence-based Home Visiting Models*

	Service Enrollment	Service Population
ABC	<ul style="list-style-type: none"> • Postnatal only • Child 6-24 mos 	<ul style="list-style-type: none"> • Families with low incomes • Families with a history of child abuse or neglect/involvement with child welfare system • Families who consider their child to be growing up in a challenging environment • Children experiencing a caregiving transition (e.g., foster care, adoption)
EHS	<ul style="list-style-type: none"> • Prenatal or postnatal • Child <36 mos 	<ul style="list-style-type: none"> • Families with incomes at or below the federal poverty level • Families with child eligible for IDEA Part C (Maryland Infants and Toddlers Program) • Other eligibility varies based on results from community needs assessments (e.g., military families, young families, children in foster care)
FC	<ul style="list-style-type: none"> • Postnatal only • Child 0-6 mos 	<ul style="list-style-type: none"> • Intends to serve all families in a community, including families with surrogate, adoptive, and bereaved parents
HFA	<ul style="list-style-type: none"> • Prenatal or postnatal • Child <3 mos 	<p>Eligibility varies based on family and community needs and existing gaps in services, but can serve:</p> <ul style="list-style-type: none"> • Families experiencing single parenthood • Families with low income • Families with a history of adverse childhood experiences • Families with substance use disorder or history of substance use disorder • Caregivers with poor mental health • Caregivers experiencing intimate partner violence
HIPPY	<ul style="list-style-type: none"> • Postnatal only • Child 2-5 yrs 	<p>Eligibility varies based on local implementation, but typically intends to serve:</p> <ul style="list-style-type: none"> • Families with low incomes • Caregivers with limited access to education • Immigrant families • Home-based child care providers
NFP	<ul style="list-style-type: none"> • Prenatal only • <28 wks gestation 	<ul style="list-style-type: none"> • Expectant caregivers, with focus on first-time caregivers • Families with low incomes or limited resources
PAT	<ul style="list-style-type: none"> • Prenatal or postnatal • Child <5 yrs 	<p>Eligibility varies based on local implementation, but typically intends to serve:</p> <ul style="list-style-type: none"> • Families at risk for child abuse • Families with history of substance use • Families with low-income • Families with children with developmental delays or disabilities • Families experiencing unstable housing

Sources: <https://homvee.acf.gov/> and model websites. * Models active in Maryland prior to 2025.

Appendix C. Workgroup Meeting Agendas

Maryland Workgroup on Newborn Home Visiting Services

September 15, 2025, 12:00pm – 2:30pm

Meeting #1

Link to Meeting: <https://meet.google.com/owm-pwaf-sqa>

Or dial: (US) +1 929-256-1204 PIN: 257 541 750#

Meeting Goals

- Build relationship / awareness of all Workgroup Members, understanding of the task at hand, and how the Workgroup will conduct its work
- Hear from families with newborns to ground our conversation in lived experience
- Establish a baseline understanding of the home visiting landscape in Maryland
- Elect a Chair and Vice Chair

Agenda

- I. Welcome and Introductions (25 min)
 - A. “Why” have you chosen the field that you are in?
 - B. “What” makes you stay?
- II. Workgroup Norms, Guiding Principles, and Starting Points (10 min)
- III. Review Legislative Charge (5 min)
- IV. Perspective of Families (15 min)
- V. The Home Visiting Landscape in Maryland – JHU/Bloomberg Presentation (25 min)
 - A. Establishing the Context of Maternal, Child and Family Well-being
 - B. Understanding the Home Visiting Landscape
- VI. Discussion (40 min)
 - A. What did you hear that was surprising?
 - B. What did you hear that should be a top priority for the Workgroup?
 - C. What more do you want to know so that we can meet our legislative responsibility with awareness of the context and resources needed?
- VII. Open to Public Comment (10 min)
- VIII. Workgroup Administrative Tasks (20 min)
 - A. Presiding Officer: MDH
 - B. MDH Website for agendas and meeting minutes (i.e., video recording)
 - C. Process for Making Decisions
 - D. Nominations and Elections for Chair and Vice Chair
 - E. Future Meetings
 - F. Follow-up Survey
- IX. Adjourn

Maryland Workgroup on Newborn Home Visiting Services

October 6, 2025, 2:00pm – 4:30pm

Meeting #2

Link to Meeting: <https://meet.google.com/hiv-yjfv-nse>

Or dial: (US) +1 727-258-2453 PIN: 782 196 722#

Meeting Goals

- Discover the benefits and opportunities for supporting the whole child and whole family through home visiting that is aligned with perinatal and early childhood systems
- Hear insights from home visitors supporting families during the perinatal period and early childhood years
- Understand Maryland’s Bright Spots that can be linked, aligned, and leveraged to create a universal home visiting system of care (*Legislative Charges 3 and 4*)
- Learn from the experience of New Jersey as that state works to build a universal newborn home visiting systems, including alignment with other models and systems, staffing, and financing (*Legislative Charges 3 and 4*)

Agenda

- 2:00pm Welcome and Approval of Minutes (5 minutes)
- 2:05pm Supporting the Whole Child and Whole Family Through Home Visiting Aligned with Perinatal and Early Childhood Systems (10 minutes)
Monique Fountain Hanna, MD, MPH, MBA
Director of State Services, BUILD Initiative
TA Advisor, Early Childhood Developmental Health Systems: Evidence to Impact Center
- 2:15pm Perspectives of Home Visitors (15 minutes)
- 2:30pm Learning from Maryland’s Bright Spots (45 minutes)
Brief Presentations
Facilitated Conversation
 - *What did you learn from the Bright Spots that we should keep in mind as we develop a vision for a universal home visiting system of support for Maryland families? For example:*
 - *What needs to be in place to ensure families are connected to home visiting programs?*
 - *How can home visiting programs be linked, aligned, and leveraged to create a system of tailored support that builds upon family strengths and needs?*
 - *How can home visiting programs coordinate with other systems – health, education, and human services?*
 - *What infrastructure is needed (common data, data sharing, centralized intake, screening/assessment/referral, etc.)?*
- 3:15pm Public Comment (10 minutes)
- 3:25pm Top of Mind (15 minutes)
 - *What is top of mind for you in this moment and why?*
- 3:40pm Learning from New Jersey’s Universal Newborn Home Visiting Program (45 minutes)
Facilitated Presentation
 - *Brandie Wooding, Director, Universal Home Visiting Program, NJ Department of Children and Families*
Facilitated Conversation

- *What questions do you have?*
- *What did you learn that we should keep in mind as we develop a vision for a universal home visiting system that would best support families with young children in Maryland?*
- *What lessons around staffing and financing should we take note of?*

4:25p

Next Steps (5 minutes)

4:30p

Adjourn

Maryland Workgroup on Newborn Home Visiting Services

October 31, 2025, 12:00pm – 2:30pm

Meeting #3

Video call link: <https://meet.google.com/wxs-ktpt-qmp>

Or dial: (US) +1 414-909-4509 PIN: 216 230 099#

Meeting Goals

- Increase understanding of pregnant and parenting families across the state as we hear from Workgroup members who conducted focus groups
- Discuss and vote on proposals related to home visiting reach, alignment, and infrastructure (Legislative Charges 1, 2, and 3)
- Engage in learning, discussion, and ideation related to the home visiting workforce and financing (Legislative Charges 3 and 4)

Agenda

- 12:00pm Welcome and Public Comment (10 minutes)
- 12:10pm Approval of Minutes and Meeting Goals (5 minutes)
- 12:15pm Perspectives of Families: Focus Group Findings (15 minutes)
- 12:30pm Workgroup Proposals on Reach, Alignment, and Infrastructure (40 minutes)
- Presentation of Proposals and Vote
- 1:10pm Home Visiting Workforce (30 minutes)
- Facilitated Presentation
- [Laura Allen, Assistant Professor, Department of Family and Community Health, University of MD School of Nursing](#)
 - [Janet Horras, Executive Director, Institute for the Advancement of Family Support Professionals](#)
- Facilitated Conversation
- *What questions do you have?*
 - *Discuss proposals related to growing the home visiting workforce that also addresses the need to increase cultural responsiveness?*
- 1:40pm Home Visiting Finance Model (45 minutes)
- Facilitated Presentation
- [Jeanna Capito, Co-Founder and Principal, Prenatal to Five Fiscal Strategies](#)
- Facilitated Conversation
- *What questions do you have?*
 - *Discuss proposals related to financing and resource needs?*
- 2:25pm Next Steps and Adjourn (5 minutes)

Maryland Workgroup on Newborn Home Visiting Services

November 20, 2025, 9:00am – 11:30pm

Meeting #4

Video call link: <https://meet.google.com/iig-dsvb-iaj>

Or dial: (US) +1 267-486-3818 PIN: 227 985 585#

Meeting Goals

- Discuss and vote on proposals related to home visiting workforce, finance, public awareness, and governance/leadership (Legislative Charges 3 and 4)
- Discuss and vote on the final Workgroup report

Agenda

- 9:00am Welcome, Meeting Goals and Approval of Minutes (10 minutes)
- 9:10am Workgroup Proposals on Workforce, Finance, Public Awareness, and Governance/Leadership (60 minutes)
Presentation of Proposals and Vote
- 10:10am Workgroup Final Report (30 minutes)
Presentation of Report and Vote
- 10:40am What Comes Next? (5 minutes)
Explanation from MDH OSS on Steps from Here to the Filed Report
- 10:45am Public Comment (10 minutes)
- 10:55am Workgroup Member's Closing Comments (35 minutes)
What worked? What didn't work? What are you proud of? What do you still hope for?
- 11:30am Adjourn